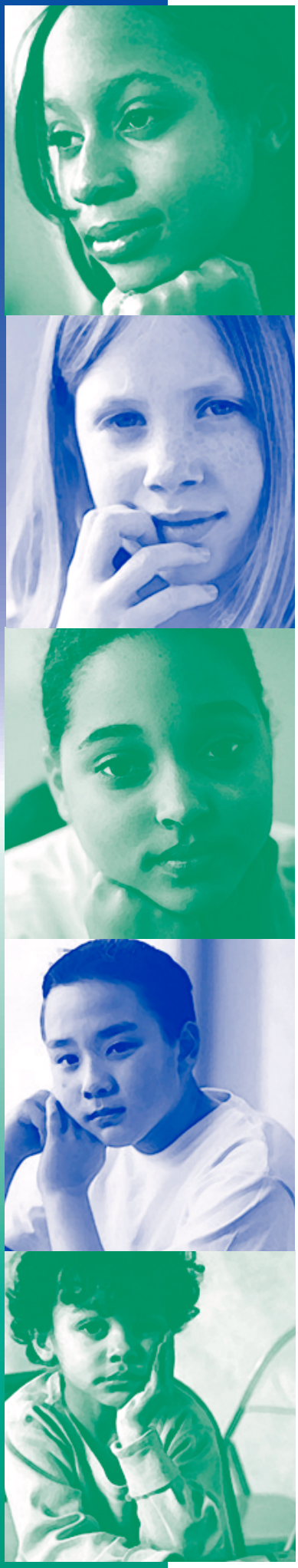

The Practice Guide to
Risk Assessment

KIDS COME FIRST

Washington State Department
of Social and Health Services

CHILDREN'S ADMINISTRATION

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Chapter One

Introduction to Risk Assessment

The Practice Guide to Risk Assessment is designed as a practical aid to support social workers and supervisors in making important decisions at critical times in the life of a case. The guide is intended to provide a better understanding of each decision point and the tools available to help make these decisions.

Guiding Principles of Kids Come First

The development of many of the risk assessment tools was part of the Kids Come First Action Agenda. The risk assessment tools are reflective of three of the primary principles of the Kids Come First Action Agenda and represent current social worker best practice. The three Kids Come First principles are:

1. Child safety is the primary mission for Children's Administration. When the interests of parents and children compete, or when there is an issue of reunification versus safety, child safety is always the paramount consideration.
2. Shared decision making results in sound decision making.
3. Critical thinking is an important part of shared decision making. Critical thinking requires that social workers collect and analyze initial data with an open mind. Judgement regarding the reliability of information about the family should be reserved until careful investigation of the facts has occurred. Social workers need to guard against collecting evidence that supports the currently held belief about the family while overlooking or dismissing evidence that challenges that belief. Decisions should be based on a factual review of all the evidence rather than a personal inner conviction about "being right." Critical thinking requires that social workers recognize that it is possible to make an error in judgement.

Once initial decisions have been made it is also important to remain open to rethinking assessments and decisions as new information becomes available. Revising a decision or assessment on the basis of new information represents good professional practice.

The Risk Assessment Model

Risk assessment is both a broad model of practice and a tool for organizing information at critical decision points that are common for every case. Risk assessment is used throughout the life of a case, from intake to reunification. Specific tools are used at each decision point to help ensure the quality and consistency of decisions. The tools guide social workers in making decisions and help supervisors to review those decisions.

The Purpose of the Risk Assessment Model

Risk assessment systems in CPS have been designed to:

- guide social workers in information gathering;
- differentiate among "low risk", "moderate risk" and "high risk" groups of families;
- reduce the likelihood of further incidents of abuse;
- ensure each risk decision is given careful consideration;
- provide a structured approach to risk decision making;
- increase accuracy, consistency, and objectivity in assessing risk;
- provide support to front line staff making risk decisions;
- improve documentation of major risk decisions; and,
- focus resources and case plans on reducing high risk factors.

Limitations of the Risk Assessment Model

Any risk assessment system should be applied to individual cases with an understanding of its inherent limitations.

The Risk Assessment Model:

- does not replace the professional judgement of well trained, experienced social workers;
- does not predict outcomes in a specific case or with a specific individual;
- only reflects an estimation of risk at a specific moment in time; and,
- is not a comprehensive assessment of all family functioning.

The Assessment Tools

The risk assessment model in Washington State examines risk at major points in the life of a case. Each tool assesses risk at different critical points in a case.

The risk assessment tools include the:

- sufficiency screen
- intake risk assessment
- safety assessment
- safety plan
- investigative risk assessment
- re-assessment of risk
- reunification assessment
- transition and safety plan
- closing risk assessment

Risk and Safety

It is important to recognize the difference between addressing safety and risk issues. When assessing safety concerns, the focus is on short term practical interventions that reasonably ensure the child's safety. Comprehensive risk assessment focuses on the likelihood of future CA/N towards a child. Risk assessment requires the collection of data across many factors associated with CA/N and implementing a longer-term approach focusing on reducing identified risk factors.

Differences Between Safety and Risk

Safety	Risk
Concerned with current conditions that may harm or endanger child now	Concerned with risk factors that are predictive of child abuse and neglect in the future
Requires immediate assessment and intervention to protect child from current threats of harm	Requires planned interventions, usually delivered through services, that are designed to decrease risk of harm
Assessment is provided by the social worker and based primarily on observation and/or interview with child and parent	Requires a comprehensive assessment of multiple risk factors provided by the social worker with input from parents, children, service providers, extended family

Decision Points and Case Management

Throughout the continuum of service for any referral, risk assessment is used in the decision making process. The following table represents key decision points and the tools used to make those decisions.

Key Decision Points	Risk Assessment Tools
Accept referral or not?	Sufficiency Screen
What is risk tag and response time?	Intake Risk Assessment
Is child safe at initial assessment?	Safety Assessment
How can child be safe in home?	Safety Plan
What is the risk of future abuse and neglect based on information collected during the investigation?	Investigative Risk Assessment
Have risk levels changed?	Reassessment of Risk
Is it safe for the child to return home?	Reunification Assessment
How will safety of the child be best assured on return home?	Transition and Safety Plan
Case Closure	Closing Risk Assessment

Risk Assessment Decision Making

1 Sufficiency Screen:

The sufficiency screen determines if a referral will be accepted for investigation or not. The sufficiency screen asks:

- Can the child be located?
- Is the alleged perpetrator the parent/caregiver of the child?
- Is there an allegation of CA/N meeting the legal definition?
- Do risk factors exist that place the child in serious and immediate harm?

2 Intake Risk Assessment:

The intake risk assessment is used to determine the initial risk tag and the CPS response time for the initial face to face contact with the child.

3 Safety Assessment:

The safety assessment is used to make immediate decisions about current safety for a child in the home. The safety assessment is used for all high standard referrals within two days of the initial face to face contact. The safety assessment is based on conditions that place children at risk of serious and immediate harm.

4 Safety Plan:

A safety plan is required if any of the safety assessment questions received an "indicated" answer if a child remains in the home. The safety plan addresses each of the safety issues that were indicated in the safety assessment. Safety planning involves family members and assigns roles to help keep the child safe. The safety plan must be completed within 2 working days of the initial face-to-face contact with the child on all emergent referrals and/or those risk-tagged 4 or 5. The safety plan must be completed within 10 working days of the initial face-to-face contact with the child on referrals risk-tagged 3.

5 Investigative Risk Assessment:

- Assesses risk factors that are most predictive of future child abuse/neglect
- Assesses protective factors that may reduce risk
- Is completed no later than 90 days from the date of the CPS referral
- Aids in developing the service plan to reduce risk

6 Re-Assessment of Risk:

Re-assessment of risk is completed at case transfer or every six months when an ISSP is not required. The re-assessment of risk is used to determine if risk levels have changed.

7 Reunification Assessment:

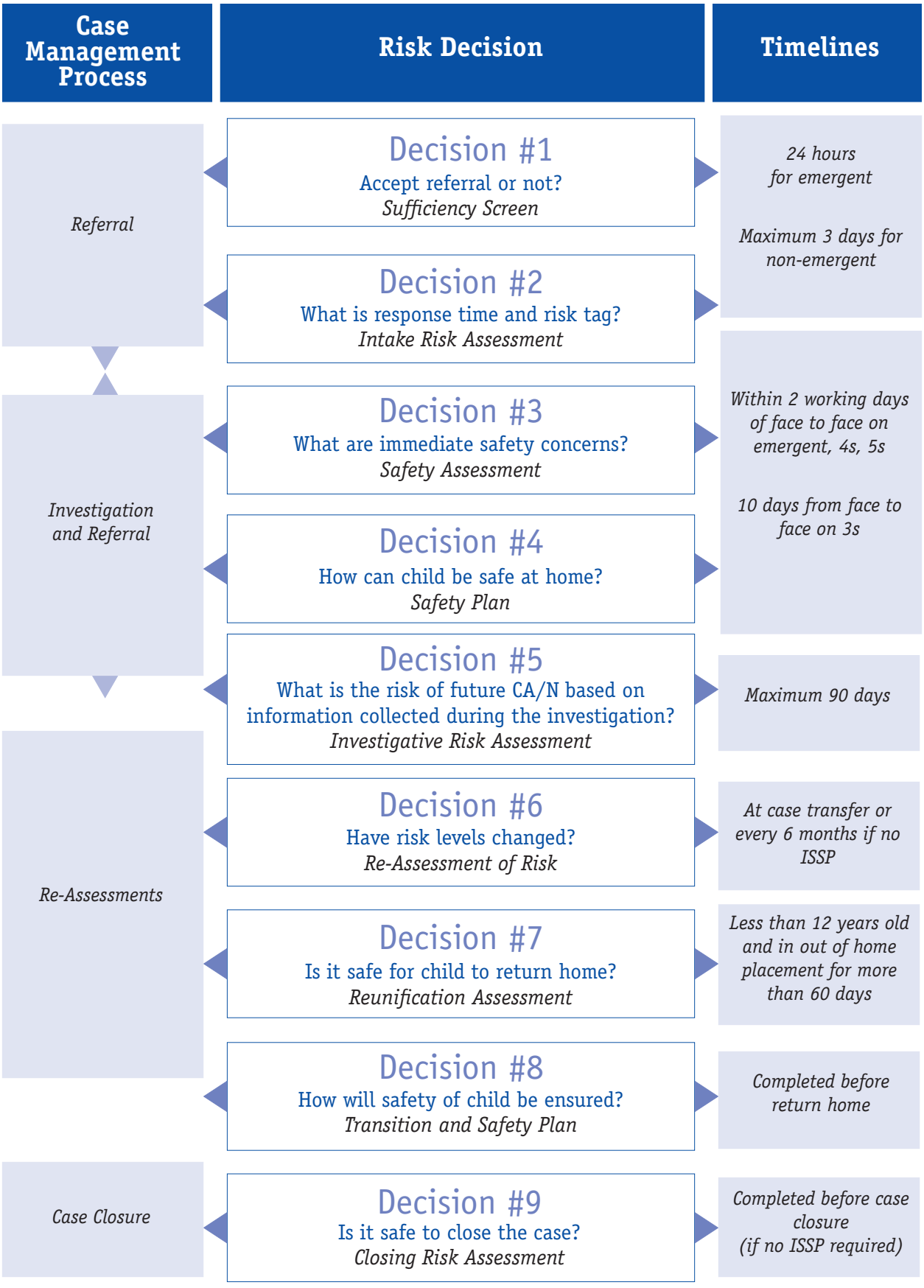
The reunification assessment is used for children 11 years and younger who have been in out of home placement 60 days or more due to child abuse and neglect to determine if it is safe for the child to return home.

8 Transition and Safety Plan:

The transition and safety plan is required if the reunification assessment indicates that it is safe for a child to return home. The transition and safety plan is developed in cooperation with family and other adults who can help assure the child's safety upon return home.

9 Closing Risk Assessment:

A re-assessment of risk is done at case closure.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Closing Risk Assessment
24 hours for emergent
Maximum 3 days for non-emergent
Within 2 working days of face to face on emergent, 4s, 5s
10 days from face to face on 3s
Maximum 90 days
At case transfer or every 6 months if no ISSP
Less than 12 years old and in out of home placement for more than 60 days
Completed before return home
Completed before case closure (if no ISSP required)

Cultural Considerations

Working with diverse families requires staff to be sensitive and knowledgeable about cultural differences. This is often a difficult task to accomplish. Risk assessment as a process is not culturally neutral. Factors that put children at risk or protect them from risk are not evenly distributed across racial and cultural groups. There are no cultural groups whose children are more "at risk" due entirely to cultural factors. There are also no cultural groups whose children are never at risk. It is important to have an understanding of the complexity of interactions between a cultural minority and the dominant culture.

As social work staff engage in risk assessment with families, it is important to recognize both cultural diversity and the differing abilities found among the parents we serve.

Chapter Two

CPS Referral and Intake

The CPS referral and intake process involves a number of steps to determine CPS intervention in a case. Those steps include:

- identifying specific CA/N allegations and/or risk of serious and immediate harm;
- completing the sufficiency screen;
- completing a person search;
- documenting current and past CPS history;
- contacting collateral sources;
- completing CAMIS intake documentation;
- evaluating risk factor information based on the intake risk assessment; and
- determining risk tag level and response time.

The Sufficiency Screen

Determining if a referral is accepted for investigation is the first key decision point made by CPS. The sufficiency screen determines if a referral is screened in for investigation or not. The quality of this decision depends on the extent and accuracy of information obtained from the referral source, other collateral sources and previously documented CPS case history. The sufficiency screen identifies specific criteria required for investigating a referral. These include:

1. **Can the child be located?**
   To answer "yes" to this question, the intake social worker must have sufficient information to locate the child. The intake social worker must utilize all available resources to locate the child. If the name of the subject and/or the victim is not known at intake, the intake social worker must provide a sufficient description of the person for the investigating social worker to be able to locate and subsequently identify the person. Local offices may develop guidelines for best practice in locating children.

2. **Is the alleged subject the parent/caregiver of the child?**
   To answer "yes" to this question:
   - the alleged subject must be a parent/caregiver of the child or someone acting in *loco parentis*, or;
   - the parent is negligent in protecting the child from further CA/N by a third party.

School personnel or childcare providers who are performing their official duties are not considered persons acting in *loco parentis*.

3. Is there an allegation of child abuse and neglect meeting the legal definition?

To answer "yes" to this question, there must be a specific allegation of CA/N meeting the legal definition. In some cases, a collection of child behaviors may imply an allegation of CA/N and may be considered an allegation for purposes of the sufficiency screen.

WAC 388-15-009 What is child abuse or neglect? Child abuse or neglect means the injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child under circumstances which indicate that the child's health, welfare, and safety is harmed. An abused child is a child who has been subjected to child abuse or abuse as defined in this section.

(1) Physical abuse means the nonaccidental infliction of physical injury or physical mistreatment on a child. Physical abuse includes, but is not limited to, such actions as:
   (a) Throwing, kicking, burning, or cutting a child;
   (b) Striking a child with a closed fist;
   (c) Shaking a child under age three;
   (d) Interfering with a child's breathing;
   (e) Threatening a child with a deadly weapon;
   (f) Doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks or which is injurious to the child's health, welfare and safety.

(2) Physical discipline of a child, including the reasonable use of corporal punishment, is not considered abuse when it is reasonable and moderate and is inflicted by a parent or guardian for the purposes of restraining or correcting the child. The age, size, and condition of the child, and the location of any inflicted injury shall be considered in determining whether the bodily harm is reasonable or moderate. Other factors may include the developmental level of the child and the nature of the child's misconduct. A parent's belief that it is necessary to punish a child does not justify or permit the use of excessive, immoderate or unreasonable force against the child.

(3) Sexual abuse means committing or allowing to be committed any sexual offense against a child as defined in the criminal code. The intentional touching, either directly or through the clothing, of the sexual or other intimate parts of a child or allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in touching the sexual or other intimate parts of another for the purpose of gratifying the sexual desire of the person touching the child, the child, or a third party. A parent or guardian of a child, a person authorized by the parent or guardian to provide childcare for the child, or a person providing medically recognized services for the child, may touch a child in the sexual or other intimate parts for the purposes of providing hygiene, child care, and medical treatment or diagnosis.

(4) Sexual exploitation includes, but is not limited to, such actions as allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in:
   (a) Prostitution;
   (b) Sexually explicit, obscene or pornographic activity to be photographed, filmed, or electronically reproduced or transmitted; or
   (c) Sexually explicit, obscene or pornographic activity as part of a live performance, or for the benefit or sexual gratification of another person.

(5) Negligent treatment or maltreatment means an act or a failure to act on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the

consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, and safety. A child does not have to suffer actual damage or physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare, and safety. Negligent treatment or maltreatment includes, but is not limited, to:

(a) Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare, and safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves;

(b) Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child; or

(c) The cumulative effects of consistent inaction or behavior by a parent or guardian in providing for the physical, emotional and developmental needs of a child's, or the effects of chronic failure on the part of a parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child.

4. Do risk factors exist that place the child in serious and immediate harm?

Serious and immediate harm is defined as: the child is in danger of abuse and neglect that could result in death, life endangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has lasting affects on a child's well-being and has a high likelihood of occurring in the immediate future.

CPS must accept for investigation referrals regarding sexually aggressive youth (SAY) when:

- Referred by law enforcement regarding a child under the age of eight who has been determined by law enforcement to have committed a sexually aggressive act.
- Referred by a prosecutor's office regarding a child under the age of 12 who has been determined by the prosecutor to have committed a sexually aggressive act but will not be prosecuted.

Other criteria for possible screen in:

- The intake social worker may accept CPS referrals that contain information regarding indicators or CA/N, but lack specific information regarding incidents, events, or conditions. Referrals are screened in if the social worker has reasonable cause to believe that a child is being abused or neglected or the risk factors place the child at risk or serious and immediate harm. In assessing risk of serious and immediate harm, the overriding concern is a child's immediate safety.

Referrals meeting the sufficiency screen criteria will be accepted for CPS investigation. CPS will only investigate a referral under these circumstances:

- questions one, two and three are answered "yes" on the sufficiency screen.
- questions one, two and four are answered "yes" on the sufficiency screen.
- all four questions are answered "yes" on the sufficiency screen.

If a referral does not meet the sufficiency screen criteria, then the referral is documented as an "information only" report. If the referral is screened in as a low standard of investigation, the case is referred to an alternative response system. An alternative response might include a phone call or letter from DCFS or a referral to a community provider.

Referrals received regarding an allegation occurring in a state operated, certified, licensed facility, or involving the biological, adoptive, or guardianship child of a licensed provider, will be referred to the Division of Licensed Resources (DLR) for investigation. Allegations of third party abuse or neglect will be referred to law enforcement.

Contacting Collaterals

Intake social workers should contact collateral information sources and record each contact when:

- sufficient information is not available from the referrer to determine if the referral should be accepted for investigation;
- it is necessary to verify or clarify an allegation of child abuse and neglect, or
- collateral sources have information that would be useful in arriving at an intake risk tag decision.

Collateral contacts should be made as soon as possible prior to making intake decisions unless:

- an emergent response is required;
- sufficient information was collected from the original referrer; and/or
- contacting collaterals may be deferred by intake in cases in which contacting collaterals at intake may compromise the impending investigation.

Intake Risk Assessment Timelines and Documentation

In most cases referrals will be entered directly into CAMIS. On those occasions where a referral has been recorded on another document, the referral information must be recorded into CAMIS within two working days.

Intake social workers generally complete an assessment of the intake the first day the referral is received. However, the referral may remain open in CAMIS for non-emergent cases for a maximum of three days if a social worker needs more time to confer with collateral sources before making a risk tag decision.

CAMIS Person Search

The intake social worker must conduct a CAMIS person search for all persons, victims, perpetrators, parents, and family members listed in the referral information. The person search provides current and past case history information for the intake social worker and is especially relevant in determining the baseline level of risk.

Decision to Accept a Referral or Not

The intake social worker reviews the referral, collateral information and case history to make a screening decision. One of the following decisions is made:

- **Information Only:** Referral does not meet sufficiency screen criteria and referral is screened out;
- **Low Risk:** Referred to alternative response system (community provider, phone call, letter);
- **Accepted for Investigation:** Referral meets sufficiency screen criteria and referral is screened in;
- **Third Party Report:** Referral does not meet sufficiency screen criteria and referral is screened out. A referral is made to law enforcement and the date is recorded on the intake form; or
- **Screened out for CPS:** Referred to Division of Licensed Resources (DLR).

Intake Supervisory Role

The intake supervisor reviews all referrals and may change the risk tag and screening decision if additional information supports the change or the supervisor determines the screening decision is incorrect based on program guidelines. Changes in the screening decision will be documented in CAMIS by the intake supervisor. The intake supervisor reviews all CPS referrals containing information regarding behavioral indicators of child abuse and neglect but lack description of allegations of CA/N.

The intake supervisor must ensure that all referrals indicating physical injury, sexual abuse, death or other crimes against a child are referred to law enforcement. The intake supervisor will also document in CAMIS all referrals that are screened out. The intake supervisor reviews all referrals whether the referral is screened in or not.

Intake Risk Assessment

If a referral meets the criteria of the sufficiency screen, an assessment of risk is completed to determine the risk tag and response time for the case. The assessment of risk establishes a baseline risk level by assessing risk factors in the following areas:

Baseline Level of Risk: History of Child Abuse and Neglect (CA/N)

Recent CA/N is the best predictor of future CA/N. The current and past history of CA/N is a complex concept that involves several factors:

- the history of well documented founded and inconclusive referrals;
- a credible eye witness of a parent's abuse;
- credible statements by the child;
- physical evidence which is confirmed by medical experts; and
- extensive intergenerational history of CA/N.

Child abuse and neglect which occurred in the distant past, but has not been repeated in the intervening time period may indicate the presence of effective protective factors.

History of child abuse and neglect can be assessed based on patterns, frequency and severity. Some examples might include:

- consistent, frequent episodes of significant/serious rejection or withholding of affection;
- pervasive neglect that may be related to a parent's addiction, cognitive impairment or mental health problems;
- battered child syndrome;
- excessive discipline of a young child;
- an escalating cycle of physical abuse;
- periodic CA/N related to a parent's mental health problems, with intervals of excellent parenting;
- physical abuse combined with domestic violence, verbal threats and intimidation; or
- sexual abuse involving one child at a time.

Child Characteristics

The level of susceptibility to child abuse and neglect is related to a child's vulnerability, ability to protect themselves, developmental delays, behavioral problems and past victimization. The risk of abuse may be reduced for a child if they:

- can care for themselves;
- have a protective non-offending parent;
- can seek help outside the home; or
- have age appropriate social and emotional development.

The factors assessed in the intake risk assessment for child characteristics are:

- vulnerability/self-protection; and
- special needs/behavior problems.

The presence of certain characteristics such as behavioral problems, physical, mental, social or developmental delays does not necessarily place a child at increased risk of abuse or neglect. Children with special needs may be at greater risk of CA/N related harm when they are being cared for by adults who have minimal commitment to the child's well being and limited coping skills to care for the special needs of the child.

Caregiver Characteristics

The following factors are used in the intake risk assessment to assess caregiver characteristics;

- substance abuse;
- mental, emotional, intellectual or physical impairments;
- parenting skills/expectations of child;
- empathy, nurturing, bonding;
- history of violence or sexual assault;
- protection of child by non-abusive caregiver;
- recognition of problem/motivation to change;
- level of cooperation with intervention; and
- history of CA/N as a child.

In any case in which a parent's substance abuse problem, mental health impairments or cognitive deficiencies incapacitates a parent for extended periods of time, social workers should ask themselves the question, "who will be caring for this child when the parent is unable to do so?"

The presence of mental health problems such as chronic anxiety, overwhelming fear or anger, serious depression, poor impulse control and post traumatic stress disorder are some of the factors which may impair a parent's ability to provide for a child's safety. The presence of these conditions does not necessarily mean that the person cannot parent adequately or that a child is unsafe.

Several of the caregiver characteristics are described in more detail in Chapter Three on Safety Assessment and later in Chapter Five on Investigative Risk Assessment.

Familial, Social and Economic Factors

The following factors are used in the intake risk assessment to assess familial, social and economic conditions:

- stress on family;
- social support for family;
- economic resources of family; and
- domestic violence.

Social support for the family is usually a protective factor. A family's social environment can either support a parent to engage in serious efforts to change the behavior or encourage them to continue in their current behavior.

Protective Factors and Family Strengths

Examples of protective factors and family strengths are listed on the intake risk assessment reference sheet on page 16. There are other factors that may also provide for the safety of the child. It is important to weigh how the family's strengths and protective factors can offset the risk factors.

How to Determine the Intake Risk Assessment Level

Some useful guidelines in assessing overall level of risk are:

- Assess chronicity and severity of risk factors particularly if they are combined with other risk or protective factors.
- Special weight should be given to the history of child abuse and neglect.
- Recent history of CA/N is the single best predictor of future CA/N.
- The number and interaction of identified high risk factors is usually more important than the presence or absence of any one factor.
- A serious history of CA/N and multiple high risk factors generally demonstrates an overall level of high risk while a less serious history of CA/N combined with multiple protective factors usually indicates an overall low risk.
- The needs and vulnerability of the child must be considered

The overall risk level may be adjusted based upon the extent and degree of protective factors that would increase or reduce the severity of the risk of CA/N. These ratings may be used to accommodate borderline situations at intake. The overall level of risk may be adjusted upward when the referral contains information about factors that are likely to increase the risk of CA/N. The overall level of risk may be reduced when the referral contains information about factors that may reduce the risk of CA/N.

While not designed as mathematical equation, the following provides a formula for assessing the overall level of risk:

Baseline + Risk Factors - Protective Factors = Overall Risk Level

The investigative risk assessment uses history of child abuse and neglect as the first risk factor. The baseline level of risk is determined by reviewing the history of child abuse and neglect.

There are cases in which history of child abuse and neglect, risk factors and protective factors do not match up in the usual ways. A single severe incident of CA/N may occur in a family with impressive strengths and few risk factors or there may be an absence of child maltreatment in a family with many high risk factors and few obvious protective factors.

Families in which multiple risk factors are present but in which evidence of CA/N is lacking are not uncommon. Many of these families may be genuinely high risk for future CA/N or there may be protective factors that have effectively reduced a child's vulnerability. The lack of evidence of past history is not enough by itself to conclude that children are at low risk of CA/N.

Many families present with a moderately serious history of CA/N and complex combinations of risk factors and protective factors. These cases require a careful assessment of the interaction of risk factors and protective factors to determine the overall level of risk.

A more thorough description is given on each of the risk factors and the process for assessing risk in Chapter Five on Investigative Risk Assessment.

Intake Risk Assessment Reference Sheet

Risk Factor	Protective Factors/ Family Strengths	Low/Moderately Low	Moderate	Moderately High/ High
I. Baseline Level of Risk: History and Description of Most Recent CA/N				
Prior History Severity/ Chronicity	There have been no incidents of child abuse or neglect in the past	Isolated incident of abuse or neglect	Intermittent incidents of abuse or neglect	Repeated or ongoing pattern of abuse or neglect
Exploitation (Non-Sexual)	Caregiver has a non-exploitative relationship with the child	Caregiver occasionally uses the child to obtain shelter or services that will benefit them both	Caregiver depends upon the child to sustain home environment and assist in illegal activities to obtain money	Caregiver engages child in dangerous activities to support or benefit the adult
Injury or Accidents	No injury and no medical treatment required	Superficial injury, no medical attention required	Significant injury, unlikely to require medical attention	Major injury requiring medical treatment
Dangerous Acts	Caregiver exercises care and control to ensure child's safety and not cause injury to child	Acts which place the child at risk of minor pain or injury	Acts which place child at risk of significant pain or moderate injury	Acts which place child at risk of impairment or loss of bodily function
Neglectful Conditions	Caregiver appropriately provides for the basic needs of child	Failure to provide routine basic needs places child at risk of minor discomfort	Failure to provide basic needs for child places child at risk of cumulative harm	Failure to provide basic needs places child at significant pain, injury or harm
Sexual Abuse	Caregiver has a non-sexualized relationship with child and protects from sexual abuse or exploitation	Caregiver makes inappropriate sexually suggestive remarks or flirtations with child	Caregiver makes sexual overtures, or engages child in grooming behavior	Caregiver engages child in sexual contact or sexually exploits child
Developmental/ Emotional Harm	Child exhibits normal behavior and social functioning	Minor distress or impairment in functioning related to ca/n	Behavior problems related to ca/n that impair social relationships or role functioning	Extensive emotional or behavioral impairment related to ca/n
II. Child Characteristics				
Vulnerability **Self Protection**	Child is willing and able to protect self	Child displays consistent ability to protect self	Child displays occasional ability to protect self	Child is unable to protect self
Special Needs **Behavior Problems**	Child displays age appropriate behavior with no physical, mental, social or developmental delays	Child displays minor behavioral problems, physical, mental, social or developmental delays	Child is behaviorally disturbed /significant physical, mental, social or developmental delays	Profound physical, mental, social or developmental delay

Intake Risk Assessment Reference Sheet

Risk Factor	Protective Factors/ Family Strengths	Low/Moderately Low	Moderate	Moderately High/ High
III. Caregiver Characteristics				
Substance Abuse	Caregiver does not abuse alcohol or drugs	History of substance abuse but no current problem	Reduced effectiveness due to substance abuse	Substantial incapacity due to substance abuse
Mental-Emotional, Intellectual or Physical Impairments	Caregiver is mentally, emotionally, intellectually and physically capable of parenting a child	A mental, emotional, intellectual or physical impairment mildly interferes with capacity to parent	A mental, emotional, intellectual or physical impairment interferes significantly with the capacity to parent	Due to a mental, emotional, intellectual or physical impairment, capacity to parent severely inadequate
Parenting Skills/ Expectations of Child	Caregiver provides environment which is child-friendly	Caregiver has some unrealistic expectations of child and/or gaps in parenting skills	Significant gaps in knowledge or skills that interfere with effective parenting	Gross deficits in parenting knowledge and skills or inappropriate demands and expectations of child
Empathy, Nurturance, Bonding	Caregiver is openly accepting of child, interacts with child, and provides appropriate and adequate stimulation	Caregiver provides inconsistent expression of acceptance, and inconsistent stimulation and interaction	Caregiver withholds affection and acceptance, but is not openly rejecting or hostile to child	Caregiver severely rejects child, providing no affection, attention or stimulation
History of Violence by or between Caregivers toward peers and/or children	Caregivers resolve conflicts in non-aggressive manner	Isolated incident of assaultive behavior not resulting in injury	Sporadic incidents of assaultive behavior which results in, or could result in, minor injury	Single or repeated incidents of assaultive behavior which results in, or could result in, major injury
Protection of Child by Non-Abusive Caregiver	Caregiver is able to protect child from dangerous persons and situations	Caregiver is occasionally unable, to protect child	Caregiver's protection of the child is inconsistent or unreliable	Caregiver refuses or is unable to protect child
Recognition of Problem/ Motivation to Change	Caregiver openly acknowledges the problem and is willing to accept responsibility	Caregiver recognizes a problem exists, and is willing to take some responsibility	Caregiver has a superficial understanding of the problem, but fails to accept responsibility for own behavior	Caregiver has no understanding or complete denial of the problem, and refuses to accept any responsibility
Level of Cooperation with Intervention	Caregiver is receptive to social worker intervention	Caregiver appears receptive to intervention and is intermittently cooperative	Caregiver appears receptive to intervention but is non-cooperative	Caregiver is extremely hostile to agency contact or involvement with family
History of CA/N as a Child	Caregiver was raised in a healthy, non-abusive environment	Occasional incidents of abuse or neglect as a child	Repeated incidents of abuse or neglect as a child	History of chronic and/or severe abuse or neglect as a child

Intake Risk Assessment Reference Sheet

Risk Factor	Protective Factors/ Family Strengths	Low/Moderately Low	Moderate	Moderately High/ High
IV. Familial, Social and Economic Factors				
Stress on Family	Family has a normal amount of life stress	Family is experiencing mild stress	Family is experiencing significant stress or life changes	Family is experiencing multiple and/or severe stress or life changes
Social Support for the Family	Frequent supportive contact with friends or relatives and appropriate use of community resources	Occasional contact with supportive persons; some use of available community resources	Sporadic supportive contact; under-use of community resources	Caregiver geographically or emotionally isolated and community resources not available or not used
Economic Resources for the Family	Family has resources to meet basic needs	Family's resources usually adequate to meet basic needs	Family's resources inadequate to meet basic needs	Family's resources grossly inadequate to meet basic needs
Domestic Violence	Parents do not engage in any domestic violence behavior	Perpetrator engages in isolated incidents of domestic violence	Perpetrator frequently engages in incidents of domestic violence	Perpetrator engages in repeated incidents of domestic violence with severe emotional/ physical consequences

Chapter Three Safety Assessment

The Purpose of Safety Assessment

The safety assessment provides a structured and consistent way to assess the child's safety. It is designed to make immediate decisions about current safety for a child in the home. The safety assessment is based on conditions that place children at risk of serious and immediate harm. The safety assessment also gives the social worker information that will help make the following determinations:

- The child is safe and can remain in the home without a safety plan in place.
- The child is safe to remain in the home with a safety plan in place.
- The child is not safe in the home and requires out of home placement.

When is a Safety Assessment Required?

The safety assessment tool is required on all high standard CPS referrals assigned for investigation when a child is to remain in the home.

Before a child is reunified with a parent following placement in out-of-home care due to abuse or neglect, and the placement is less than 60 days in duration, a safety assessment/safety plan or transition and safety plan is required prior to the reunification of the child.

When is a Safety Assessment not Required?

The safety assessment is not completed for children who are placed out of the home through a voluntary placement agreement, court order or protective custody.

Safety Assessment Timelines and Documentation

A safety assessment is required immediately following the initial face-to-face contact with the child for all CPS referrals risk tagged 3, 4 or 5 if the child is to remain in the home. The safety assessment can be initially documented on a NCR form or directly into CAMIS. In either case the safety assessment must be documented in CAMIS according to the following timelines:

- The safety assessment on referrals assessed as emergent and/or risk tagged 4 or 5 will be documented in CAMIS or completed on an NCR form within two working days of the initial face-to-face contact with the child. If the NCR form is used initially, the safety assessment will be documented in CAMIS within ten working days of the initial face-to-face with the child.
- The safety assessment on all referrals risk tagged three will be documented in CAMIS or completed on an NCR form within ten working days of the initial face-to-face contact with the child. If the NCR form is used initially, the safety assessment form will be documented within ten working days of the completion of the NCR form.

- If the safety assessment is completed on an NCR form, a hard copy of the form must be included in the case file.

Safety Assessment Definitions

Serious and Immediate Harm

The child is in danger of abuse and neglect that could result in death, life endangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has lasting effects on the child's well-being.

The following are examples of caregiver actions that might place a child at risk of serious and immediate harm:

- seriously physically harming a child or sexually abusing a child in the recent past;
- torturing a child;
- engaging in a pattern of non-supervision of an infant, toddler or preschooler;
- not providing basic needs to an infant, toddler or preschooler;
- failing to obtain medical care for a seriously ill or seriously injured child;
- not providing care for the child, due to substance abuse, mental illness or cognitive impairment;
- abandoning a child;
- forcing a child to steal, commit violent acts or engage in prostitution; and
- knowingly placing a child in the immediate proximity or care of dangerous individuals.

Note: These examples do not include all conditions or circumstances of risk of serious and immediate harm.

Child Safety

Child safety is a condition in which a child is protected from serious and immediate harm.

Incident

An incident is an event that actually occurred. An incident is more than an allegation. There must be reasonable corroborating factual information to support that an incident actually occurred.

Indicated

Indicated means that the information available to the worker reasonably suggests or demonstrates that the statement is true.

Not indicated

Not indicated means that the information available to the worker reasonably suggests or demonstrates that the statement is not true or that not enough information is available for the worker at the time the safety assessment is completed to reach a conclusion of "indicated".

Completing the Safety Assessment

Gathering factual family information is critical in assessing child safety. Information gathered in a fair minded, objective way, with a readiness to listen can help to establish a working relationship between social workers and parents. Such an approach is beneficial for a number of reasons:

- It increases the likelihood of obtaining reliable information from parents for the safety assessment.

- Parents can provide information that others may not have.
- It increases the likelihood that parents will be cooperative in the implementation of a safety plan.

The safety assessment is often completed with urgency within a limited timeframe to reasonably ensure a child's safety. It is important to remember that all relevant information for each question may not be readily available within the first few days. The social worker completes the safety assessment with the information available at the time of the initial assessment. If the social worker does not have enough information to reasonably suggest that the answer to any question is yes, then the social worker chooses "not indicated".

A safety assessment considers all children in a family rather than only the identified victim. Where possible, information for the safety assessment should be gathered from multiple sources to help provide the most complete picture of safety for the child. The sources of information can include reports from family members, child interviews and professionals. Contacts with collateral sources are also highly encouraged. The social worker should also review relevant available written reports and documentation.

How to Determine Child Safety

If any one of the questions on the safety assessment is marked "indicated", then a safety plan must be developed. If multiple questions are marked "indicated" on the safety assessment, there may be a heightened concern for the safety of the child. The severity and number of questions marked on the safety assessment should be considered in making placement decisions. Out of home placement does not always occur when several questions are marked "indicated". A child may remain in the home if a safety plan can be developed that reasonably assures the child's safety. If the risk of harm is so high that there is no room for error then it is not prudent to develop a safety plan or leave the child in the home. No safety plan can completely guarantee a child's safety.

While a safety assessment may indicate there are no immediate safety concerns and not require a safety plan, it does not mean that a child will be safe at a later time. New information may be received at a later date that indicates a change in a child's current safety needs. In each case, any new information needs to be considered.

Connecting the Safety Assessment to the Safety Plan

Each question on the safety assessment that receives an answer of "indicated" needs to be clearly and specifically addressed in the safety plan. There should be a clear link between each identified safety factor in the safety assessment and the identified safety measure put in place in the safety plan. Supervisory approval is given for safety plans that address the safety issues that received an "indicated" response in the safety assessment. Supervisory approval is also needed for safety plans that were required but not developed. Certain situations may occur which preclude the development of a safety plan, including:

- the safety plan can not reasonably assure the child's safety in the home (and an alternate placement has been made);
- the parent flees with the children; and/or
- The parent refuses to cooperate with a plan after reasonable efforts have been made to solicit their participation.

Safety Assessment Question One

Has there been an incident of high-risk physical abuse, sexual abuse or neglect of any child in the family in the last 90 days (consider current referral)?

High Risk Examples:

Physical Abuse	Sexual Abuse	Neglect
shaking an infant	child is forced to touch adult's breast or genitals	deprived of food, water
banging a child's head	pornographic involvement of child	based on age appropriate needs
torturing a child	child is forced into prostitution	pattern of rejection by caregiver
broken bones skull fractures	adult touches child's breasts or genitals without medical/ hygiene reason	deprived of appropriate clothing for weather and age
hitting with closed fist or kicking in stomach or head	adult engages in sexual penetration with child	extreme isolation of school age child
escalating physical injuries	STD in child not sexually active with peers	deprived of medical, dental and mental health attention
inflicted burns	child is forced to engage in sexual activity with another child	young child left home alone or unsupervised
extensive bruising	child forced to watch or perform sex with an animal	hazardous conditions in the home
		severe lack of nurturance of infant

2 Safety Assessment Questions

Safety Assessment Question Two

Does a caregiver of any child within the family or a person with frequent access to the child have a history of serious violence toward children, history of sexual abuse of children, or a history of exploitation of children?

A caregiver or a person with frequent access is defined as a parent or adult person living in the home on a permanent or semi-permanent basis.

The caregiver's history may indicate that a child is at risk rather than unsafe. Recent history that has occurred in the last 90 days is of greatest relevance. It is important to ask several questions when considering the caregiver's history.

Those questions include:

- Is the history recent or significantly in the past?
- Was the history an isolated incident or recurring frequently?
- What have been the patterns and frequency of past offenses?

More weight should be given to recent history and patterns of repetitive behavior than an isolated event that occurred in the distant past. When considering history, social workers should focus on behavior and criminal activity as it relates to crimes against children.

Information about the caregiver's history can be confirmed by credible sources such as:

- case history;
- law enforcement;
- family members; and
- others with direct knowledge.

Examples of High Risk Behavior Towards Children:

Serious violence	Sexual Abuse	Exploitation
parent has previous founded referral for CA/N resulting in serious injuries	adult inappropriately touches child's breasts or genitals	engages child in serious criminal behavior
child witnesses serious assault or violent death of family member	pornographic involvement of child	engages child in drug sale or transporting
adult threatens child with deadly weapon or has deadly weapon present during a domestic violence incident	child is forced into prostitution	rewards child for assaulting others
child witnesses suicide attempt	STD in child not sexually active with peers	creates drug dependency in child
child witnesses torture or death of pet by caregiver	child exposed to prostitution in the home	child is forced to work long hours compromising health, education and well-being
parent has been convicted of assault crime against a child	adult engages in sexual penetration with child	child is indentured to third party for monetary benefit
child is forced to participate in or observe acts of domestic violence		

Safety Assessment Question Three

Is there a pattern of neglect/incidents/injuries involving any child in the family, which is escalating in severity?

This question focuses on repeated behavior that is increasing in frequency and severity. It also addresses behavior that has resulted in increasingly serious and severe consequences for the child. A pattern of behavior may not necessarily constitute CA/N but the pattern needs to be explored and explained before safety can be reasonably assured.

Patterns of ongoing physical abuse that are becoming more severe should be assessed as well as physical and medical neglect. Consider repeated efforts by numerous people at educating or encouraging parents to address the patterns of injuries that have occurred within the family. These efforts may have occurred over a number of years and circumstances and possibly with other children.

The following chart gives examples of patterns of behavior. In addressing this question, the severity and frequency of the patterns also needs to be assessed.

Examples of Patterns of Behavior:

Physical Abuse	Physical Neglect	Medical Neglect
a history of bruises and abrasions especially on non-contact areas a pattern of non-accidental cigarette burns, scalds and/or branding history of wearing bandages, casts, braces due to non-accidental sprains or fractures	unresolved health conditions worsening due to lack of appropriate hygiene, food, clothing or heat in the home a pattern of accidental injuries due to burns, access to exposed wiring, poisons, weapons and firearms repeated attempts by child to harm self with no parental intervention	long standing and/or unresolved health issues due to parents lack of follow through with medical care a pattern of minor injuries that become seriously infected child suicide attempt with no parental follow up for counseling

Failure to thrive may be caused by:

- an underlying medical disorder
- by caregiver actions or inactions, or
- may be a combination of the two situations.

4 Safety Assessment Questions

Safety Assessment Question Four

Have there been dangerous acts (including severe domestic violence), omissions, or plausible threats by a caregiver or person with frequent access to the child that have placed the child at risk of serious harm in the last 90 days (consider current referral)?

This question addresses issues associated with behavior that has occurred in the last 90 days which includes the current referral. This question is not concerned with events in the distant past. Dangerous acts do not necessarily result in injury to the child. However, worker should pay particular attention to escalating patterns of violence.

Plausible threats are when there is a reasonable expectation that the threat to the child is serious and that the parent's past behavior indicates the likelihood that the parent would follow through with the threat.

Dangerous acts of domestic violence, acts of omission or plausible threats that result in child endangerment whether or not adjudication has occurred should be considered. Some of these acts may include:

- failing to give prescribed medication to a child with a seizure disorder;
- holding a child during a domestic violence incident when objects are thrown
- domestic violence perpetrator may threaten to kill the mother when a child is present; and
- domestic violence perpetrator violates any court order prohibiting contact with child.

During the past several years, many domestic violence counselors have challenged the assumption that domestic violence reflects a lack of impulse control. It is now frequently maintained that perpetrators of domestic violence often act in a highly calculating way, which is congruent with their beliefs and values. Violence directed at a spouse or partner increases the probability that children will be physically abused, in part because violent individuals often believe in the usefulness of force to maintain control of family members. Children may sometimes be harmed or threatened by perpetrators of domestic violence as a means of intimidating other family members. Children may also be physically harmed merely by being present when a violent altercation is occurring (i.e., being caught in the crossfire). Children acting in a protector role may also find themselves in harms way. In addition, a child's development may be impacted as a result of assuming a parental/caregiver role due to parental incapacitation from injuries sustained during domestic violence. In sum, there is a rapidly increasing body of evidence regarding the negative emotional and developmental effects of domestic violence on children.

Safety Assessment Question Five

Is there a caregiver whose judgement, impulse control, reality contact, and/or ability to parent is severely impaired at the present time due to substance abuse, mental illness, developmental delay, or other condition?

This question focuses on the current impact of substance abuse, mental illness and developmental delay on a caregiver's judgement, impulse control, reality contact and parental capacity. There are two steps in answering this question:

First, there is a need to determine if the caregiver at the time of the referral has a mental illness, a developmental delay or a substance abuse problem. The presence of these conditions does not mean that the person cannot parent adequately or that a child is unsafe. Similarly, substance abuse does not automatically result in a child being unsafe.

How much mental illness, developmental delay or substance abuse impairs parenting ability will depend on:

- the nature, diagnosis and symptoms of the illness;
- the nature and extent of the developmental delay;
- the nature and extent of the substance abuse;
- whether or not there is another caregiver in the home able to compensate for the affects of the afflicted caregiver's functioning; and/or
- the development, health and other needs of children in the home.

The second step involves assessing the impact of these conditions on the caregiver's ability to meet the child's immediate safety needs. The task is to determine if the parental ability is severely impaired, not just impaired or impacted by their condition. This is usually determined through observation of the caregiver's ability to anticipate and provide for the child's basic needs and in particular, the child's immediate safety needs.

Specific characteristics which are generally indicative of severely impaired parental ability include:

- judgement;
- impulse control; and
- reality contact.

5 Safety Assessment Questions

Examples of Severe Impairment of Ability to Parent:

Judgement	Impulse Control	Reality Contact
patterns of marked cognitive or perceptual distortion	episodes of failure to resist aggressive impulses	delusions, hallucinations
inability to know cause and effect		
substance abuse in situations in which it is physically hazardous, such as driving	frequent explosions of temper/ emotions or acting out behavior	catatonic behavior or grossly disorganized behavior
placing a child in an at-risk situation when there is adequate available information to indicate the risk	difficulty controlling anger	grossly disorganized speech, incoherent
		unable to know time, day, surroundings, primary relationships

Safety Assessment Question Six

Is there an individual with frequent access to the child who is a registered sex offender or who has been convicted of a felonious assault in the last five years?

This question focuses on adjudication and the information regarding adjudication will be found in a criminal history check or may already be documented in the case file.

A list of registered sex offenders can be found at some county sex offender websites but these are not always current and may only list the level three sex offenders. The most reliable source for current sex offender information can be obtained by contacting the local law enforcement office.

It is important to note the type and history of the sex offense. Some sex offenses may be against adult women only. This type of sex offense should be noted in the safety assessment and the safety plan, although further investigation may demonstrate that there is not a safety issue for the child. The following are examples of questions that should be asked when determining if a registered sex offender poses a safety threat to a child:

- What was the age of the victim?
- What was the preferred gender?
- How much time has elapsed since the last offense?
- What was the age of the offender at the time of the last offense?
- Has the offender successfully completed a sex offender treatment program?
- Is there a court order restricting access to children?

7 Safety Assessment Questions

Safety Assessment Question Seven

Does the child express fear of people living in or frequenting the home?

This question addresses the type of fear that causes emotional distress or trauma. Most children have some fear about normal discipline and getting into trouble. It is also important to have a solid understanding of fears that are consistent with child development. Child behavior that may be cause for concern might include:

- draws pictures that depict fears;
- exhibits fear of caregiver by hiding from caregiver;
- cries inconsolably, screams or cowers when touched by caregiver;
- verbalizes fear of repeated abuse;
- seeks protection from others outside the home;
- refuses to go to caregiver; or
- child runs away from home and is afraid to return.

8 Safety Assessment Questions

Safety Assessment Question Eight

Is there any other concern that places a child in this home at risk of serious and immediate harm?

This question provides an opportunity to identify any additional concerns that were not addressed in the other seven questions. Each situation is unique and should be evaluated on an individual basis. Issues should be identified here that specify reasonable safety concerns that place the child at risk.

CHILDREN'S ADMINISTRATION

Washington State Department of Social & Health Services

Safety Assessment

Example (Not based on an actual case)

If the child is not in out-of-home placement *this Assessment is to be completed immediately following the initial face to face contact with the child and documented per CA policy.* ***This assessment is based on the information available at the time of its completion.***

If any of the following questions are answered "indicated" the child will be considered at risk of serious and immediate harm. **Serious and immediate harm** means the child is in danger of CA/N which could result in death, life endangering illness or injury requiring medical attention or result in traumatic emotional harm or severe developmental harm which could have lasting effects on a child's well-being. **Indicated** means that the information available to the worker suggests or demonstrates that the statement is probably true. **Not indicated** means that the information available to the worker suggests or demonstrates that the statement is probably NOT true; OR that not enough information is available for the worker to reach a conclusion of "Indicated".

Case Scenario: Sandra, a single mother, puts her two children (5 year old Joey, and 1 year old Lucy) to bed at 8:30 p.m. She then leaves the children alone after they have fallen asleep; she returns around 2 a.m. This happens once or twice per week.

DATE OF ASSESSMENT: 11/14/01

Child's name:	Joey Brown - age 5 Lucy Brown - age 1	Case Number: 43L000000-0
Parent name:	Sandra Brown	Child's Medical Provider: Dr. Randolph Hegge

	Indicated	Not indicated
1. Has there been an incident of high-risk physical abuse, sexual abuse or neglect of any child in the family in the last 90 days (consider current referral)? *Any incident that rises to the level of the high-risk examples given in the ASSESSMENT OF RISK - SECTION I of the Companion Guide requires an answer of "indicated" on this question.*	X	
2. Does a caregiver of any child within the family or a person with frequent access to the child have a history of serious violence toward children, history of sexual abuse of children, or a history of exploitation of children? *Adjudication is not required. Victims of previous violence or abuse do not necessarily have to be the children named in the current referral.*		X
3. Is there a pattern of neglect/incidents/injuries involving any child in the family, which is escalating in severity? *Although this question is primarily concerned with CAN related incidents, the worker is reminded not to discount a series of injuries that may have been labeled "accidents" but which continue to escalate in severity.*		X

	Indicated	Not indicated
4. Have there been dangerous acts (including severe domestic violence), omissions or plausible threats by a caregiver or person with frequent access to the child that have placed the child at risk of serious harm in the last 90 days (consider current referral)? *Adjudication is not required. Consider offenses involving substance abuse, gangs, and other actions that may be considered "child endangering."*		X
5. Is there a caregiver whose judgement, impulse control, reality contact, and/or ability to parent is severely impaired at the present time due to substance abuse, mental illness, developmental delay, or other condition? *This determination relies mostly on observation and/or input from credible sources including friends and family members.*		X
6. Is there an individual with frequent access to the child who is a Registered Sex Offender or who has been convicted of a felonious assault in the last five years?		X
7. Does the child express fear of people living in or frequenting the home? *Such fear must relate to a real likelihood of CA/N in the near future and/or retaliation by the caregiver for the child's cooperation with CPS.*		X
8. Is there any other concern that places a child in this home at risk of serious and immediate harm? *This question is intended to allow the worker to include any dangerous situations, actions, and/or omissions that are not addressed in the previous questions. Describe:*_____		X

NOTE: If any item above is checked "indicated," Children's Administration policy requires a safety plan in the absence of compelling reasons to the contrary.

If any item above is "indicated" AND no safety plan is implemented, explain why below. Supervisory approval of the lack of a safety plan is required.

_____

_____

_____

_____

_____

_____

Supervisory Approval _____ Date _____

Chapter Four

Safety Planning

The Purpose of Safety Planning

Safety planning is a documented plan to help keep the child safe. Safety plans are developed in order for the child to remain in the home. The safety plan addresses each of the safety issues that were indicated in the safety assessment. Safety planning encourages family members and others to share the responsibility for keeping children safe. Safety planning helps to identify the roles and responsibilities of various adults in keeping children safe.

When is a Safety Plan Required?

Safety plans are required when any question on the safety assessment is answered "indicated" and the child is remaining in the home.

If a child is reunified with a parent following placement in out-of-home care due to abuse or neglect, and the placement is less than 60 days in duration, a safety assessment/safety plan or transition and safety plan will be completed prior to the reunification of the child.

If a safety plan is required but is not developed, the social worker must document in CAMIS the reason for not implementing a plan. Conversely, a plan may be developed on any case even though the policy may not require it.

When is a Safety Plan not Required?

A decision to place the child outside the home may occur when the safety concerns are very high. In these cases where the safety concerns are very high it is generally not prudent to develop a safety plan.

A safety plan is not required in these circumstances:

- The safety plan can not reasonably assure the child's safety in the home
- the parent flees with the children; or
- the parent refuses to cooperate with a plan after reasonable efforts have been made to solicit their participation.

Special Considerations: Division of Licensed Resources (DLR)

When DLR completes a safety plan, regarding biological, adoptive, or guardianship children, the case will be immediately transferred to DCFS for services and monitoring. DLR will continue to complete the investigation and assessment of the case. The DCFS social worker will not make a finding or complete an investigative summary assessment. For additional information, please refer to the DLR Practice Guide.

Characteristics of Effective Safety Planning

Safety plans are most effective when they:

- focus on the child's safety needs;
- increase the child's visibility;
- include a number of parties who share the role of assuring child safety;
- are realistic and achievable;
- are developed in consultation and agreement with parents;
- are specific, detailed and contain timelines for completion; and
- clearly identify the roles and responsibilities of various adults in helping to keep the child safe.

Timelines and Documentation

If a safety plan is required, it must be completed and documented in CAMIS within two working days of the initial face-to-face contact with the child on all emergent referrals and/or referrals risk-tagged at four or five. The safety plan must be completed and documented in CAMIS within ten working days of the initial face-to-face contact with the child on all referrals risk-tagged three.

Supervisors are required to review safety plans within ten working days, or sooner at the discretion of the social worker and supervisor, on all emergent referrals and/or those risk-tagged at four or five. Safety plans for referrals that are risk tagged three are reviewed by supervisors at monthly case conferences.

The supervisor will review the current status of the Safety Plan with the social worker and note any chanbges in family circumstances that may affect the safety of the child. The safety plan must be reassessed and reviewed as circumstances change.

The safety plan can be documented on an NCR form or in CAMIS. If an NCR form is used, the social worker still needs to then record the safety plan in CAMIS. Safety plans should be signed by those involved including the parents and any others who are participating in the safety plan. Documented verbal agreement is also acceptable where signatures are not possible or not possible to obtain in a timely manner.

If a safety plan is required but is not developed, the social worker must document in CAMIS the reason for not implementing a safety plan. Though not required, a safety plan may be used on any case.

Completing the Safety Plan

The Safety Plan should be developed in conjunction with all parties enlisted (shared planning format) to ensure the safety of the child. Plans are to be regularly monitored and reviewed and changed as circumstances dictate. Any revisions to plans should be communicated to all involved.

Service planning is not safety planning. The following chart notes the differences between safety planning and service planning.

Differences in Safety and Service Plans:

Safety Plans	Service Plans
Are based on limited information and assessment and used to protect a child from serious and immediate harm by concrete steps and immediate action that addresses the danger or threat Requires more frequent monitoring by the responsible adults identified in the plan to help keep the child safe until more information is available Communication about the plan is usually by phone and focuses on child safety Are changed quickly as new information is learned or situations within the family change Changes in the plan are agreed upon verbally or by signature for those who participate in the plan to help keep the child safe Are used when limited information is available and longer range plans have not been implemented	Are based on a comprehensive assessment of risk and used to decrease risk of future harm to children by influencing and changing parental behaviors over time Are monitored by a variety of professional service providers for client compliance and progress Communication about the plan is by phone, written evaluations, reports and meetings and focuses on family functioning Are generally changed at more regular intervals to assure enough time to properly evaluate the effectiveness of the service Changes in the plan occur as a result of client progress, recommendations from service providers and permanency guidelines Changes in the plan usually occur through consultation, observation of client compliance and progress and court orders

The Safety Plan Form

Reason for Agreement

The plan should identify each question in the safety assessment that was "indicated" and what the specific concern was for each question.

Date

The date indicates when the plan was written.

Safety Plan for the Child

The plan should include all children in the family in addition to the identified victim.

What will be Done/By Whom

The safety plan should address each of the issues that were indicated in the safety assessment. Each activity of the safety plan should help to reasonably ensure the child's safety. The safety plan should be specific, concrete and clearly understood by all parties involved. Each item should identify:

- the name of the person responsible for accomplishing each task;
- the process for monitoring the activity; and
- the dates when the task should happen or be completed.

Signatures

It is important that parents are included in the development of the safety plan. Parent involvement will help ensure a better outcome for the child's safety. The parent's signature is not required to implement a safety plan. If parents are not willing to sign a safety plan, a supervisor should be consulted to determine the likelihood of parental compliance. A parent who is unwilling to sign a safety plan does not necessarily equate an unwillingness to comply with the safety plan. Likewise, a parental signature does not necessarily guarantee compliance to the plan.

Follow Up for the Safety Plan

It is important that all parties involved in helping to assure the safety of the child be given a copy of the finalized plan. Information should also be shared to make sure there is clarity on the following issues:

- the role and responsibility of each person in the safety plan;
- a plan to monitor parental compliance for the safety plan;
- actions to take if the family's situation changes;
- contact person if the child's safety needs are not being met; and
- timeline for reviewing the safety plan.

Safety Plan Examples

- The child will attend school regularly and meet with the school counselor each day.
- The father agrees to no physical discipline.
- The child will spend one evening per week and one day per weekend with the maternal grandmother.
- The children will attend childcare, *provider's name*, three times per week.
- The parents will work with the IFPS provider on parenting and discipline techniques.
- The mother agrees to remove all alcohol from the home by a *specified date*.
- The aunt will visit the mother and children twice per week in the evening on *designated days*.

- The grandmother and mother will take the children to the doctor for a physical and developmental assessment by a *specified date*.
- The mother will provide the social worker with names, birth dates and social security numbers of all proposed caregivers by a *specified date*.
- The father will call the paternal aunt for support twice per week and request respite before he begins drinking.
- The mother will call the maternal aunt and police if her boyfriend attempts to return to the home.
- The father will bring the children to their grandmother's home each weekend for Saturday overnight visit.
- The mother agrees to see a psychiatrist for depression by a *specified date*, refill necessary prescriptions and begin taking medication with the aunt taking the mother to appointments.
- Information will be provided to school age child regarding how to seek help if further CA/N occurs.
- Selection of who will care for child or be responsible for care 24 hours per day will be identified.
- The mother will work weekly with the public health nurse with specific dates and issues to address.
- Referrals will be made to community supports to help parents meet basic needs.

Safety Plan

Example (Not based on an actual case)

CHILDREN'S ADMINISTRATION

Washington State Department of Social & Health Services

Required for all children for whom the Safety Assessment yields an "indicated" in any of the question fields.

The following is an agreement between Sandra Brown and Children's Administration for the period _____now_____ to ___then_____.

Goal of Agreement: *The worker should be specific in listing immediate threats to the safety of the child that this agreement seeks to address.* **These children are too young to be left unsupervised. This agreement will immediately increase safety by outlining childcare solutions and a monitoring plan.**

What will be done	By Whom
1) Sandra agrees to not leave her children unattended under any circumstances for any length of time.	Sandra
2) When Sandra is called into work in the evening or needs to leave the home for any reason, Sandra's mother (Grandma Joan) agrees to come to Sandra's home and provide childcare.	Grandma Joan
3) If Grandma Joan is not available, Sandra's neighbor (Irene) agrees to serve as backup.	Irene
4) If neither Grandma Joan nor Irene is available, Sandra will inform her employer that she is unable to come in and will cancel any and all plans to leave the home.	Sandra
5) Beginning immediately, Grandma Joan will randomly check a minimum of three times a week (by phone or in person) to see if the children are being properly supervised in the evening.	Grandma Joan
6) Sandra agrees to contact her mother weekly to plan ahead (to the degree possible) her childcare needs.	Sandra
7) Joey knows his Grandma Joan and Irene's phone numbers and understands that he is to call one of them if his mother leaves he or his sister unattended.	Joey
8) Sandra, Irene and Grandma Joan all agree to contact the social worker immediately if the children are left unattended or if the plan starts to break down in any way.	Sandra, Irene and Grandma Joan
9) Social worker will call both Sandra and Grandma Joan once a week to ensure that the plan is working.	Social worker
10) Social worker will perform CPS and criminal background checks on both Grandma Joan and Irene when she returns to the office tomorrow.	Social worker

Failure to comply with this agreement may result in the filing of a dependency petition and recommendation that the children be placed out of the home.

Signatures (If participant does not sign, then the social worker will document date agreement reached with participant for their participation in the plan):

_____ _____
Signature *Date*

_____ _____
Signature *Date*

_____ _____
Signature *Date*

_____ _____
Signature *Date*

Chapter Five

Investigative Risk Assessment

The investigative risk assessment is the fifth step in case decision making and answers the question, "What is the risk of future abuse and neglect based on information collected during the investigation?" The investigative risk assessment examines 16 risk factors that practice and research have shown are most predictive of future abuse and neglect without intervention into the current situation.

Refer to the Risk Assessment Decision-Making Chart on page five and the Risk Decision Flow Chart on page seven in Chapter One.

The Purpose of Investigative Risk Assessment

The investigative risk assessment provides a structured approach to assessing risk of future child abuse and neglect and to differentiate children that are at low, moderate and high risk of abuse.

The investigative risk assessment identifies:

- history of CA/N;
- current risks;
- current protective factors;
- overall level of risk; and
- areas to be addressed in the service plan.

Timelines and Documentation

The investigative risk assessment is to be completed at the end of the investigation and documented in CAMIS no later than 75 days from the date of the referral. All findings whether founded, unfounded, or inconclusive, must have a justification for the decision documented. There should be a brief identification of the evidence gathered and considered in the making of all findings within a referral. A brief narrative stating the basis/evidence for the finding(s) for each victim should be documented.

Evidence considered may include; but is not limited to:

- Victim disclosure including initial and subsequent disclosure or recantations;
- Eyewitnesses icluding name, relationship to child and summary of information;
- Law enforcement information including name, agency and summary of information;
- Medical/Health professionals information including name, agency and summary of information;

- Other information witnesses including name, relationship to victim and summary of information;
- Supporting documents, photographs, records, video or audio recordings and other physical evidence;
- The lack of the above evidence; and/or
- Inconsistent disclosures or statements.

Investigative Risk Assessment

The investigative risk assessment identifies sixteen risk factors (including history) that have statistically been shown to predict risk of future abuse and neglect.
Those sixteen factors include:

History of Child Abuse and Neglect

- description of most recent CA/N (History of CA/N prior to current allegations. Include victimization of any chid and describe injuries or accidents relating to CA/N, dangerous acts/ neglectful conditions, extent of sexual abuse, and developmental/emotional harm.)

Child Characteristics

- vulnerability/self protection
- special needs/behavior problems

Caregiver Characteristics

- substance abuse
- mental, emotional, intellectual or physical impairments
- parenting skills, expectations of child
- empathy, nurturance, bonding
- history of violence by or between caregivers toward peers and/or children
- protection of child by non-offending caregiver
- recognition of problem/motivation to change
- history of CA/N as a child
- level of cooperation with intervention

Familial, Social and Economic Factors

- stress on family
- economic resources for the family
- social support for the family
- domestic violence

Risk Factors

History of Child Abuse and Neglect

The investigative risk assessment uses the history of child abuse and neglect to determine the baseline level of risk. The investigative risk assessment places the history of CA/N in the forefront of the risk assessment process by requiring a narrative description of CA/N, for both recent and past history. The rationale for this structure is the belief that the best predictor of future behavior is past behavior.

The first rule of risk assessment is to pay careful attention to the history of CA/N. In assessing the history of CA/N it is important to also address chronicity and severity. Chronicity is defined as recurrent episodes of abuse and neglect over time and identifies a family pattern of child maltreatment rather than a one time isolated incident. Severity is defined as the degree of the abuse.

The history of CA/N is a strong predictor of its future occurrence. Chronic CA/N indicates a pattern of child maltreatment. Habits have payoffs or rewards, which make them difficult to change. It does not matter if the reward is negative or positive.

Chronic CA/N also indicates the failure of social norms and self-regulation to influence behavior, that is subject to social disapproval and/or civil and criminal sanctions. Once a person has crossed the psychological barrier preventing this behavior from occurring it may be easier to continue engaging in the behavior. Severe CA/N also indicates an extreme lack of empathy. A caregiver that cannot or will not take into consideration the amount of damage or injury to a child shows that there is no internal stop sign that prohibits them from harming a child.

In considering the history of CA/N, a review of the history should include both founded and inconclusive referrals. An inconclusive finding means that it was not possible to determine one way or the other whether CA/N occurred. In the review of the history, it is also important to note a pattern of incidents similar to the current allegation.

When assessing past history of CA/N based on CAMIS documentation, it is important to consider:

- genuine uncertainty regarding allegations does occur;
- children or parents may change their accounts of past incidents following a new referral;
- social worker bias may interfere in making sound judgement; and/or
- there may be past inconclusive or unfounded referrals from reliable sources alleging CA/N which now may appear true given new allegations.

Baseline Level of Risk: History and Description of Most Recent CA/N

Prior History

Severity/Chronicity

Family Strengths/ Protective Factors	There have been no incidents of abuse or neglect in the past
Low/Moderately Low Risk (1, 2)	Isolated incidents of abuse or neglect One incident of abuse or neglect Intermittent incidents of abuse or neglect
Moderate Risk (3)	More than one incident of abuse or neglect separated by long intervals of non-abusive or non-neglectful behavior
Moderately High/ High Risk (4, 5)	Repeated or ongoing pattern of abuse or neglect Abuse occurs periodically as conditions and situations vary Abuse occurs regularly on a daily or weekly basis Neglect is ongoing and constant with infrequent interludes of appropriate care For an infant or preschool child, a dangerous pattern may occur within a period of hours, days or weeks For an older child, a dangerous pattern may emerge over a period of weeks to months

Exploitation

(Non-Sexual)

Family Strengths/ Protective Factors	Caregiver has non-exploitative relationship with the child
Low/Moderately Low Risk (1, 2)	Caregiver exaggerates or promotes child's vulnerability to obtain food or shelter Caregiver has child do entertainment activities occasionally to obtain money for basic needs
Moderate Risk (3)	Caregiver demands that child work outside the home and relinquish most of earnings to adult for his/her own use Caregiver expects child to do all the household tasks including meal preparation and laundry Child is frequently forced to miss school to care for younger siblings or adult Caregiver uses child for illegal non-violent activities such as betting, selling stolen items
Moderately High/ High Risk (4, 5)	Caregiver engages child in property crimes such as robbery, auto theft, burglary Caregiver uses child to sell or transport drugs Caregiver forces child to work full-time and relinquish all earnings for adult's use Caregiver indentures child to third party for monetary benefit

Injury or Accidents

Family Strengths/ Protective Factors	No injury and no medical treatment required
Low/Moderately Low Risk (1, 2)	Inflicted bruises confined to extremities and buttock that do not require medical treatment Superficial welts, scratches or abrasions confined to knees, shins, arms and buttocks
Moderate Risk (3)	Any bruises on pre-ambulatory child or child under age one Bite marks with breaks in the skin Cuts, bruises, abrasions, on protected body areas such as inner thighs, neck, genitalia Cuts, bruises, or abrasions on facial area such as eye, cheek, lip, forehead, nose Multiple superficial injuries Patches of hair pulled from child's scalp First and/or second degree burns confined to a small area of child's hand, leg, or arm
Moderately High/ High Risk (4, 5)	Cuts that require stitches Head injuries, i.e. concussion, retinal or cerebral hemorrhage, skull fractures Broken bones Extensive and multiple bruises Third degree burns to any area of the body Displaced joints First and/or second degree burns on face, abdomen or genitals Injuries resulting in significant sight, hearing, or mental impairment Evidence of neck injury that interferes with breathing Near drowning, inflicted

Dangerous Acts

Family Strengths/ Protective Factors	Caregiver exercises care and control to ensure child's safety and not cause injury to child
Low/Moderately Low Risk (1, 2)	Forcing child to eat small amounts of an inappropriate food item such as Tobasco sauce, hot peppers, soap Allowing toddler on elevated surface without close supervision Pulling child off floor by arm or leg
Moderate Risk (3)	Dragging child by hair Biting child Twisting or pulling body parts, such as arms, wrists, ears Locking child in area without a means of escape Denying food for more than two consecutive meals Forcing a child to eat a non-food item Tying child down or using restraining devices such as handcuffs, ropes, chains Throwing hard objects at child Forcing young child to be outside in cold or rain Hitting child with an implement Making child stand in corner for excessive time periods Pulling out patches of hair
Moderately High/ High Risk (4, 5)	Shaking an infant Spanking an infant Any physical discipline to an infant Interfering with a child's breathing Hitting child with fist or implement on head, neck, stomach, abdomen, genitals, or kidneys Throwing child against wall or other surface Holding head of young child in toilet bowl Head banging Threatening child with a deadly weapon Leaving child unattended in a hot car Burning a child Using electric shock as punishment Driving with child while under influence of drugs or alcohol Denial of food or water for 24 hours Forcing child to eat foods in amounts that might be toxic Introducing into a child's body any substance which could temporarily or permanently impair bodily functions Assaultive behavior which poses a physical threat to the safety of the child Smearing feces or urine in a child's face Munchausen's by Proxy

Neglectful Conditions

Family Strengths/ Protective Factors	Caregiver appropriately provides for the basic needs of child
Low/Moderately Low Risk (1, 2)	Child's clothing is consistently dirty or in need of repair Child has insufficient clothing for current weather Toilet facilities are not immediately available but are within a reasonable distance Shelter is only sporadically heated in the winter, causing child some discomfort Regular meals provided but may be nutritionally poor
Moderate Risk (3)	Shelter does not provide adequate protection from the elements Inadequate provisions for sleeping such as rough surface, dirty, smelly, noisy, damp Food provided is inadequate to sustain a healthy, growing child Infant is not fed regularly Infant or young child not bathed regularly, causing itching, rash, matted hair Infant's diapers changed irregularly, causing rashes or significant discomfort
Moderately High/ High Risk (4, 5)	Child is not sheltered from the elements Sleeping provisions are cold, wet, or unsafe Food is not provided, or only provided sporadically for child Child has no access to clean water Infant is not fed within twelve hours Clothes are inadequate to protect child from elements Toilet facilities are unavailable Infant or young child smells strongly, has a painful skin condition, hair or teeth loss Bathing facilities are not available for an older child Infant left in soiled diapers for extended periods of time, resulting in a bleeding, painful skin condition

Sexual Abuse

Family Strengths/ Protective Factors	Caregiver has a non-sexualized relationship with child and protects from sexual abuse or exploitation
Low/Moderately Low Risk (1, 2)	Caregiver makes sexually suggestive remarks or flirtations with child without clear overtures or physical contact Caregiver makes sexual innuendoes, provocative statements, or lewd comments to child Sexual activities are discussed inappropriately in front of child Pornographic media material is viewed in child's presence or available for child to see it
Moderate Risk (3)	Caregiver engages in sexually stimulating grooming behavior with child Child is propositioned or pressured to have sexual contact Caregiver exposes self to child or masturbates in child's presence Child is encouraged or forced to view pornographic material Caregiver engages in sexual activities in front of child Child is photographed in provocative poses or clothing Caregiver does not intervene in inappropriate sex play between siblings
Moderately High/ High Risk (4, 5)	Child is engaged by an adult or older child in sexual penetration Child is forced by an adult to engage in sexual activity with another child Child is engaged in masturbation by an adult or older child Child is engaged in sadomasochistic practices Caregiver forces child to watch or perform sex with an animal Pornographic photographs are taken of child Caregiver forces child to act out sexually in front of them or others Caregiver pressures or forces child to engage in sexual activity with another adult Child has a sexually transmitted disease Child is unsupervised in the presence of a known sex offender

Developmental/Emotional Harm

Family Strengths/ Protective Factors	Child exhibits normal behavior and social functioning
Low/Moderately Low Risk (1, 2)	Child has some negative attention-seeking behavior Lack of impulse control Limited attention span Child displays minor behavioral problems
Moderate Risk (3)	Emotional or social impairment resulting in social isolation Sadness caused by CA/N resulting in decreased capacity to perform age-appropriate tasks Depression evidenced by listlessness, withdrawal or daydreaming, impairing academic performance and/or peer relationships Signs of anxiety or fear that interfere with learning new skills or making new friends Antisocial behaviors, chronic lying, destruction of property, stealing Habitually running away Failure to meet early development milestones
Moderately High/ High Risk (4, 5)	Fire setting Lack of emotional attachments Non-organic "failure to thrive" Assaultive behavior Sexual victimization of younger child Mutilation of animals Severe psychological reaction such as suicide attempt, self-mutilation, loss of ability to speak, extreme social fear Severe depression which immobilizes child or leads to suicidal behavior Habitual delinquent behavior leading to recurrent involvement with criminal juvenile justice system Chronic ridiculing, belittling or humiliation of child Terrorizing a child

Child Characteristics

The level of susceptibility to child abuse and neglect is related to a child's vulnerability, ability to protect themselves, developmental delays, behavioral problems and past victimization. Research, practice and child mortality studies indicate that younger children are more likely to be severely harmed as a result of child maltreatment.

Vulnerability/Self Protection

Family Strengths/ Protective Factors	Child is able to consistently protect self
Low/Moderately Low Risk (1, 2)	May escape or hide to avoid abuse Recognizes the behavior as abusive but can not consistently avoid it May be able to physically resist abuse May not consistently seek help from non-offending parent
Moderate Risk (3)	Child displays occasional ability to protect self Child is unable to distinguish between abuse and discipline School-age child has reduced ability for self-care Child is unable to leave abusive situations Child occasionally seeks assistance to protect self Child has a relationship with person outside the home, not consistently available for protection Child is reluctant to be with parent Child is fearful of retaliation from parent Child is fearful of home environment due to domestic violence, drug/ alcohol use, dangerous people and/or health and safety issues
Moderately High/ High Risk (4, 5)	Child is unable to protect self Child views abuse as normal and acceptable Child lives or is left in unsafe environments Child is not supported in efforts to seek help or protection Child is unable to communicate Child is unable to seek assistance Child is 0 - 5 years old or a child with special needs Child has no visibility in the community Child blames self for abuse Child recants or denies substantiated abuse Child hides or minimizes injuries

Special Needs/Behavior Problems

Family Strengths/ Protective Factors	Child displays age appropriate behavior with no physical, mental, social or developmental delays
Low/Moderately Low Risk (1, 2)	Child displays minor behavioral problems, physical, mental, social or developmental delays Child often has age-appropriate behaviors Child has minor illness/medical condition requiring periodic parental attention Child has mild developmental delay Child has minor hyperactivity or depression Child has minor school problems or occasional truancy
Moderate Risk (3)	Child is behaviorally disturbed/significant physical, mental, social or developmental delays Irritable and/or distressed baby is difficult to console Child has medical condition, physical disability or psychological condition requiring regular parental and/or medical attention Child has been diagnosed with attention deficit disorder, fetal alcohol syndrome or some other condition Child has behavior problems which interfere with academic performance and social relationship with peers Child has significant pattern of aggression or withdrawal at school, home or with friends Child is periodically absent from school or runs away for short periods of time Child may exhibit inappropriate behavior for their age Child has difficulty concentrating at school Child is overeating, losing weight or other changes in diet Child is occasionally violent and dangerous to others Child displays some self-destructive behavior Child destroys objects Child has sleep disorders Child experiments with drugs and alcohol
Moderately High/ High Risk (4, 5)	Profound physical, mental, social or developmental delay Low birth weight and/or medically fragile infant Child has extreme and challenging behaviors requiring almost constant management and supervision Child is reliant on parent for total care due to physical/developmental disability Child regularly uses drugs and/or alcohol Child's behavior causes regular removal from academic and social environments Child exposes himself to risky situations without knowledge of danger Child is violent and dangerous to others and self Child has criminal history Child is involved in coercive, aggressive sexual behavior Mutilation/killing of animals

Caregiver Characteristics

The risk factors identified under caregiver characteristics provide information about the history and present parenting function of the child's caregiver. Since the following caregiver risk factors are predictive of future abuse and neglect, it is important to gather reliable information about each factor.

Substance Abuse

Substance abuse may interfere with a person's ability to perform essential life functions such as parenting, work, interpersonal relationships and self-care.

Family Strengths/ Protective Factors	Caregiver does not abuse alcohol or drugs and is not involved in selling illegal drugs.
Low/Moderately Low Risk (1, 2)	History of substance abuse but no current problem Has completed treatment and remained free from substance abuse for more than one year Is voluntarily involved in treatment, has regularly attended support groups or meetings for at least six months Infrequent use of alcohol which occasionally impairs parenting skills or abilities
Moderate Risk (3)	Reduced effectiveness due to substance abuse or addiction Parent's use of drugs and/or alcohol results in erratic and unreliable parenting of child Social and/or support network includes known abusers of drugs and alcohol Has failed treatment programs or has not completed treatment in past Has begun treatment although has not established consistent participation Heavy use is occasional, weekends or situational, rather than an established pattern indicating addiction
Moderately High/ High Risk (4, 5)	Substantial incapacity due to substance abuse or addiction Parent's use of substances results in inability to meet any of the child's basic needs Use of substances results in emotionally abusive and/or violent behavior Drug-using or drug-making paraphernalia accessible to children History of DUI/DWI and/or drug/alcohol-related criminal activities Inability to maintain employment due to substance abuse Denial of impact of substance abuse on parent's ability to provide for child's needs

Mental, Emotional, Intellectual or Physical Impairments

In any case in which mental health, emotional, intellectual or physical impairments incapacitates a parent for extended periods of time, social workers should ask themselves the question, "who will be caring for this child when the parent is unable to do so?" The presence of these conditions does not necessarily mean that the person cannot parent adequately or that a child is unsafe.

Family Strengths/ Protective Factors	Caregiver is mentally, emotionally, intellectually and physically capable of parenting child
Low/Moderately Low Risk (1, 2)	A mental, emotional, intellectual or physical impairment mildly interferes with the capacity to parent Parent has some mild physical or emotional impairment causing minimal interference with some daily activities Parent has emotional problems for which he/she is receiving effective treatment Parent has low tolerance for stressors and may react in emotionally inappropriate ways Parent has developmental delay and relies on consistent support to manage daily activities Parent has low self-esteem, anxiety attacks and mood swings that minimally impact parenting functions
Moderate Risk (3)	A mental, emotional, intellectual or physical impairment interferes significantly with the capacity to parent Parent has a physical, mental or emotional impairment that interferes with daily parenting activities Parent is being supervised by a physician for physical, mental or emotional condition but does not consistently comply with treatment plan Parent is depressed and unable to provide nurturance and stimulation to child Parent requires consistent support to manage daily activities but does not have the help required
Moderately High/ High Risk (4, 5)	Due to a mental, emotional, intellectual or physical impairment, capacity to parent severely inadequate Acute or chronic illness or disability that significantly impairs the parent's ability to care for child Parent has serious mental illness but refuses to participate in treatment plan Parent's physical, mental or emotional impairment causes them to be vulnerable to dangerous situations Parental impairment causes failure of parent to recognize dangers and protect children from harm Parent has history of injuries, assaults, exploitation due to physical, mental or emotional impairment Parental behavior may include delusions and hallucinations Parent has history of suicide attempts

Parenting Skills/Expectations of Child

Parenting skills and expectations of the child should demonstrate an ability to provide for a child's basic needs and to guide, educate, and discipline in a way that facilitates a child's positive social and emotional development.

Family Strengths/ Protective Factors	Parent provides environment that is child friendly
Low/Moderately Low Risk (1, 2)	Parent has some unrealistic expectations of child and/or gaps in parenting skills Parent is inconsistent in disciplining child based on age and behavior Parent does not consistently offer assistance or encouragement to promote child's healthy development Parent has some understanding of normal child development
Moderate Risk (3)	Parent has significant gaps in knowledge or skills that interfere with effective parenting Parent has limited understanding of child's developmental stage, skills and abilities Parent consistently demonstrates unrealistic expectations of child Parent assigns child responsibilities that exceed child's developmental skills and abilities Parent reacts with a consistently negative response to child Parent engages in harsh physical punishment
Moderately High/ High Risk (4, 5)	Parent has gross deficits in parenting knowledge and skills or inappropriate demands and expectations of child Parent has little or no understanding of child's developmental skills and assigns child tasks beyond their capacities Parent scapegoats child, assigning blame and engaging in physical punishment Parent punishes child for age appropriate behaviors Parent does not intervene when young child is in dangerous situations Parent demonstrates helplessness and hopelessness to control child's dangerous or out-of-control behaviors Parent rewards child for anti-social and/or negative behaviors Parent does not express affection or interest in child Parent does not recognize or respond to child's needs

Empathy, Nurturance, Bonding

Empathy nurturance and bonding with a child requires a parent to be appropriately responsive to a child's feelings, situation and motives. It also requires that parents provide a strong emotional connection, consistent loving care, and acceptance with a commitment to the overall well being of the child.

Family Strengths/ Protective Factors	Parent is openly accepting of child, interacts with child and provides appropriate and adequate stimulation
Low/Moderately Low Risk (1, 2)	Parent provides inconsistent expression of acceptance and inconsistent stimulation and interaction Parent rarely praises child although can identify strengths and positive qualities in child if asked Parent is critical when child makes normal developmental mistakes or errors Parent is overly protective of child limiting interaction with peers, family members, community
Moderate Risk (3)	Parent withholds affection and acceptance but is not openly rejecting or hostile to child Parent rarely enjoys company of or spends time with child Parent isolates child from rest of family or social situations Parent is punitive when child makes normal developmental mistakes Parent demonstrates frequent lack of interest in child's activities, interests or accomplishments Parent uses belittling language when talking to or about child Parent rarely demonstrates verbal or physical affection toward child Parent does not recognize nor intervene when child needs help
Moderately High/ High Risk (4, 5)	Parent severely rejects child, providing no affection, attention or stimulation No demonstration of attachment or bonding between child and parent Parent is physically rejecting of child, providing no attention or affection Parent expects child to meet own needs Parent makes statements to child that devalue, demoralize and reject Child is immediately friendly with strangers, clinging to or seeking physical affection

History of Violence by or Between Caregivers Toward Peers and/or Children

Parent has caused physical or sexual injury to another person not limited to family members or children. Information is supplied by a credible source that has direct knowledge of the caregiver's violent or sexually assaultive behavior.

Family Strengths/ Protective Factors	Parent resolves conflicts in non-aggressive manner
Low/Moderately Low Risk (1, 2)	Parent has engaged in isolated incident of assaultive behavior not resulting in injury Parent has engaged in yelling, shoving or other physically aggressive behaviors with children and/or adults that have not resulted in injuries Parent has a history of violence and has successfully participated in credible treatment program designed to address violent behaviors Parent has history of referrals of physical abuse toward children
Moderate Risk (3)	Parent has sporadic incidents of assaultive behavior which result in or could result in minor injury Parent has engaged in physical altercations with children and/or adults resulting in minor injuries Parent has occasionally engaged in abusive/assaultive or intimidating behaviors toward children and/or adults Parent's family, social contacts or others express fear of the parent's assaultive behavior Parent has difficulty in work, social or other situations as a result of intimidating and aggressive language and behaviors
Moderately High/ High Risk (4, 5)	Single incident or repeated incidents of assaultive behavior which results in or could result in major injury Parent has had a prior founded referral for child abuse Parent engages in behaviors with children and/or adults resulting in serious injuries Parent frequently engages in abusive/assaultive/intimidating behaviors toward children and/or adults Parent has an arrest history of assault or crimes against others Parent's family, social contacts or others are afraid of the parent and avoid contact with the parent Parent has a history of restraining orders against them for violence or assault Parent has refused, failed, or not completed treatment and persists in violent behavior

Protection of Child by Non-Abusive Caregiver

The non-abusive caregiver acknowledges the threat that the abusive caregiver poses to child and possesses the capabilities and resources necessary to protect the child and keep the child safe from harm.

Family Strengths/ Protective Factors	Parent is able and willing to protect child from dangerous persons and situations
Low/Moderately Low Risk (1, 2)	Parent is willing but occasionally unable to protect the child Parent is willing to protect child although lacks confidence in ability to do so Parent provides protection by having child stay with appropriate friends or relatives
Moderate Risk (3)	Parent's protection of child is inconsistent or unreliable Parent obtains protection order but allows for violation of the order Parent questions or doubts need to provide protection for child Parent maintains relationship with perpetrator of abuse Parent allows supervised contact between perpetrator and child Parent questions child's account of abuse
Moderately High/ High Risk (4, 5)	Parent is unwilling to protect child Parent does not follow through with obtaining protection order Parent allows contact between child and perpetrator Parent does not recognize danger posed by perpetrator Parent remains committed to relationship Parent leaves child alone with alleged perpetrator Parent blames child for abuse Parent pressures child to deny or recant reports of abuse

Recognition of Problem/Motivation to Change

The recognition of the problem and the motivation to change are two separate issues. Both issues help determine a parent's commitment and ability to make positive change. Both indicators must be positive in order for a positive outcome to be completely supported. If both indicators are negative, a negative outcome would be most likely.

There may be circumstances where one indicator is positive and the other indicator is negative. A parent who does not fully recognize the problem but is motivated to change may have difficulty changing the behavior since there is limited insight into the problem. If highly motivated however, the parent may over time gain the insight required to resolve the issues. A parent that recognizes the problem but has limited motivation to change will also be hindered in making progress unless circumstances change to increase the parent's motivation to alter the behavior.

The rating assigned under these circumstances will best be determined by case specifics. A parent that recognizes the problem but is debilitated by depression may be unable to take the necessary steps to change. The rating would indicate lower risk if the parent was aware of the affects of the depression and expressed willingness to seek professional help.

Parents who are able to process new information about the behavior toward their children are more likely to experience positive outcomes. In contrast, if parents are unwilling or unable to process new information regarding the problem, progress will be limited and the risk greater.

Recognition of the problem and the motivation to change involves a parent's acknowledgment and awareness of CA/N issues combined with a readiness and commitment to change regardless of how difficult, painful, or costly those changes might be.

Family Strengths/ Protective Factors	Parent openly acknowledges the problem and is willing to accept responsibility
Low/Moderately Low Risk (1, 2)	Parent recognizes a problem exists and is willing to take some responsibility Parent recognizes but may not understand problem Parent understands that child has been affected by CA/N but does not understand the consequences to the child Parent is initially angry at allegations but later agrees to comply
Moderate Risk (3)	Parent has a superficial understanding of the problem and fails to accept responsibility for own behavior Parent projects blame onto the child or others Parent minimizes impact of the problem on the child and/or family Parent overestimates child's resilience and ability to cope with physical and emotional abuse Parent makes statements and promises indicating willingness to make changes but fails to follow through
Moderately High/ High Risk (4, 5)	Parent has no understanding of the problem and refuses to accept any responsibility Parent maintains denial although presented with evidence Parent believes that behavior is socially accepted norm Parent denies emotional and behavioral impacts of problem/abuse on child Parent refuses to change behaviors to alleviate CA/N Parent has support of family and social network that supports continued CA/N

History of CA/N as a Child

A parent's history of CA/N as a child includes a parent's experience of physical abuse, sexual abuse, neglect and emotional abuse by caregivers in a manner that had the potential to result in significant physical, developmental or emotional harm.

Family Strengths/ Protective Factors	Parent was raised in healthy, non-abusive environment
Low/Moderately Low Risk (1, 2)	Parent had occasional incidents of abuse or neglect as a child Parent remembers incidents of harsh punishment although did not perceive it as abuse Parent recalls some abusive discipline Parent's siblings were abused but parent was not Parent was victim of abuse and received support and protection from other family members
Moderate Risk (3)	Parent had repeated incidents of abuse or neglect as a child Parent reports basic needs not frequently met Parent received harsh physical punishment on a regular basis resulting in frequent injuries Parent has no sense of belonging or attachment to a family Parent experienced a lack of consistent parenting by a loving caregiver Parent has a history of hostile and verbally assaultive relationship with own parents
Moderately High/ High Risk (4, 5)	Parent has history of chronic/severe abuse as a child Parent reports being a victim of severe neglect that resulted in physical problems Parent was victim of assaults resulting in broken bones, physical disability, or emotional trauma Parent was victim of sexual abuse and received no support, protection or affirmation from family Parent recalls repeated beatings and/or physical attacks Parent recalls no appropriate discipline Parent reports severe emotional rejection, scapegoating and humiliation by own parents Parent was deprived of food, clothing, rest, medical attention as a form of punishment

Level of Cooperation with Intervention

A parent's level of cooperation is determined by a family's willingness to work in partnership with DCFS and service providers toward child safety, case closure, permanency and reunification.

Family Strengths/ Protective Factors	Parent is receptive to social worker intervention
Low/Moderately Low Risk (1, 2)	Parent accepts intervention and is intermittently cooperative Parent expresses willingness to participate in service plan but occasionally fails to follow through Parent appears angry and uncooperative but complies with service plan
Moderate Risk (3)	Parent accepts intervention but is non-cooperative Parent does not consistently comply with service plan Parent undermines attempts to provide services Parent undermines communication between service providers and social worker Parent is verbally abusive toward service providers and social worker Participation is unproductive, conflict-ridden, argumentative and/or parent is passive giving no attention to the service Parent demonstrates no change in behavior despite service participation Parent expresses justification for problem and/or abusive behaviors
Moderately High/ High Risk (4, 5)	Parent is extremely hostile to agency contact or involvement with the family Parent refuses to work with social worker and/or service providers Parent continues to blame others for abuse after intervention Parent threatens violence with social worker/service providers Parent refuses to support child in services Parent prevents social worker or service providers from seeing child Parent avoids contact with social worker and service providers Parent has extensive CPS history of non-compliance Parent has past history of termination of parental rights Parent flees with child to avoid CPS intervention and the CPS social worker is unable to contact after numerous attempts

Familial, Social and Economic Factors

Familial, social and economic factors are defined as employment status, family stress and social support. The presence or absence of these factors has been shown to impact the level of risk of CA/N in families.

Stress on Family

Stress on the family includes life events that significantly diminish the ability to provide basic needs for the child.

Family Strengths/ Protective Factors	Family has normal amount of stress and is able to manage it effectively
Low/Moderately Low Risk (1, 2)	Family is experiencing mild stress Parent experiences difficulty managing disruptions in household Minor irritants lead to emotional distress for parent Parent has difficulty maintaining perspective and mood stability under normal stress Parent has limited income and regularly struggles to meet basic needs
Moderate Risk (3)	Family is experiencing significant stress Crisis and/or losses have led to intense anxiety, depression or frequent family conflict Parent has ongoing conflict with intimate partner and/or intense conflict with siblings and extended family members Parent has lost significant portion of financial income Parent has chronic physical/medical problems resulting in pain and emotional discomfort
Moderately High/ High Risk (4, 5)	Family is experiencing multiple and/or severe stress or life changes Parent has been evicted from housing and is homeless Parent has lost major source of financial income Parent has recently experienced the death of a child or other family member Parent has recently experienced divorce or the loss of a intimate partner

Social Support for Family

Social support includes ongoing positive social contacts from extended family, friends and community that contribute to the overall well being of family members.

Family Strengths/ Protective Factors	Frequent supportive contact with friends and relatives with appropriate use of community support Parent is involved with activities outside the home Family is open to feedback and support from network
Low/Moderately Low Risk (1, 2)	Family is supportive, but not close by Community services are available but difficult to access or too infrequent Family is new to the area and has yet to access social supports Parent does not see the services being provided as helpful Parent has social acquaintances but no close friends, family or intimate partners
Moderate Risk (3)	Family lives in an isolated area and are unable to access community or family supports There are limited community resources available Services may be offered to the family but remain inaccessible due to language barriers or the service provider's lack of familiarity with the culture of the family Parent asks for help only when they are in crisis The support the family receives from family and friends is inconsistent/ unreliable Social contacts are not emotionally supportive and some may be emotionally destructive Parent cannot maintain friendships or casual social acquaintances
Moderately High/ High Risk (4, 5)	Parent has no one to turn to for emotional support or practical assistance in crisis or emergency Family is geographically isolated and has no means to access help or support in times of emergency or crisis, e.g.) transportation, telephone Parent is hostile and threatening toward offers of help with basic needs even though family is suffering Primary parent is largely restricted to the home with little opportunity for periodic relief from continuous interaction with child(ren) Family is alienated from, or has an ongoing conflict with, extended family, friends, or neighbors

Economic Resources of Family

Economic resources for a family might include income from:

- employment
- public assistance,
- charitable contributions
- extended family or friends

Income from these resources is available to meet the family's basic physical needs

Family Strengths/ Protective Factors	Family has resources to meet basic needs
Low/Moderately Low Risk (1, 2)	Parent works long hours or multiple jobs to make ends meet Family lacks resources to meet educational, recreational, social needs Family is unable to seek regular medical care due to financial limitations Family seeks help from extended family, community and charities to supplement the meeting of basic needs
Moderate Risk (3)	Family can minimally meet basic needs but crisis leaves family without means to provide for basic needs Family lives in unsafe environment due to lack of resources Family member has ongoing medical condition but is unable to treat due to lack of financial resources Family is dependent upon extended family, community and charities to meet basic needs
Moderately High/ High Risk (4, 5)	Family resorts to illegal means to provide financial support Family member has life-threatening medical condition that goes untreated due to lack of financial resources Family has no access to supports that can provide help with basic needs Family lacks a source of income to meet basic needs Family's resources are so limited that parents must juggle meeting needs based on level of crisis

Domestic Violence

A pattern of verbal, physical, sexual and economic assaultive and coercive behaviors that occurs between intimate partners with one partner dominating the other.

Family Strengths/ Protective Factors	Parents do not engage in any domestic violence behavior
Low/Moderately Low Risk (1, 2)	Perpetrator engages in isolated incidents of domestic violence Perpetrator engages in socially isolating behaviors with partner, limiting partner's contact with friends and family Perpetrator engages in pushing and shoving partner Perpetrator uses emotionally abusive language toward partner Child may be present or witness domestic violence
Moderate Risk (3)	Perpetrator frequently engages in incidents of domestic violence Perpetrator is frequently emotionally abusive toward partner Perpetrator threatens or harms family members causing minor injuries Perpetrator threatens to harm family pets Perpetrator uses finances to control behaviors/life of family members Perpetrator destroys property Perpetrator cuts partner off from family and other social supports Child may try to intervene or seek help from others
Moderately High/ High Risk (4, 5)	Perpetrator engages in repeated incidents of domestic violence with severe emotional/physical consequences Perpetrator coerces partner into sexual relations in front of children Perpetrator engages in patterns of physical assaults, threats or intimidation of partner Perpetrator isolates partner and partner is punished if outside contact occurs Perpetrator uses/threatens to use weapons to harm family members Perpetrator does not allow partner access to finances and controls all expenditures Perpetrator does not allow partner access to transportation Non-offending partner denies violence despite evidence Non-offending partner appears detached, withdrawn or emotionless in light of extreme violence Perpetrator severely injures or kills pet as a means of intimidation There are repeated police interventions for DV Perpetrator threatens to kill partner if attempts are made to leave Child is physically harmed during DV altercation Non-offending parent is frequently hospitalized for serious physical injuries due to DV Perpetrator has refused, failed, or not completed treatment and persists in violent and coercive behavior

Protective Factors

Research regarding protective factors is not nearly as extensive as the research of risk factors related to CA/N. The relative influence of protective factors on CA/N is still a matter of judgement, as is the extent in which various protective factors reduce the risk of CA/N when present in families with multiple risk factors. Nevertheless, there is considerable empirical support for the importance of a core group of protective factors including:

- empathy/nurturance;
- social support, especially for neglecting families;
- parenting skills and knowledge;
- adequate income to meet basic needs of family; and
- child's age greater than 5 for CA/N related physical harm.

Protective factors and risk factors can often be viewed as a continuum with risk on one end of the continuum and protection on the other. Limited or no social support is a risk factor for CA/N while appropriate social support is usually a protective factor. Parenting skills and knowledge, empathy, nurturance, economic resources and cooperation with the agency are other factors that can be assessed along a continuum.

Other protective factors cannot be adequately described as the opposite of risk factors. Substance abuse is a risk factor for CA/N, but the lack of substance abuse may not be a protective factor unless it is combined with a commitment to the recovery process for persons in recovery from drug/alcohol abuse. Domestic violence is a risk factor for CA/N but lack of domestic violence may not serve as a protective factor unless family members strongly believe in practicing nonviolent ways of resolving conflict.

A single severe incident should never be taken lightly regardless of the presence of multiple protective factors. What is needed in these cases is an in-depth understanding of how and why the CA/N incident occurred, despite numerous protective factors, before deciding that the family is low risk for future CA/N.

Protective factors decrease the risk of harm by:

- reducing children's physical or emotional vulnerability;
- increasing internal or social prohibitions against CA/N;
- providing support and assistance from extended family and community;
- increasing parent's understanding of children's needs; and
- reducing stress to provide for family's basic economic needs.

Examples of Protective Factors

The following are examples of protective factors:

Child Characteristics

Protective Factors

- child is able to protect self
- child has age appropriate developmental abilities
- child has other adults available to meet needs
- child has visibility within school or child care setting

Caregiver Characteristics

Protective Factors

The caregiver:

- is free from substance abuse
- follows through on medical treatment plan
- maintains good health
- uses medical care for self and child appropriately
- understands child's capabilities in relationship to age and intellectual development
- has history of putting child's needs before their own
- makes appropriate child care/supervision arrangements
- has undertaken steps to address/change the situation
- does not allow the offender in the home
- has history of meeting the child's basic physical and emotional needs
- is able to protect child from dangerous persons and dangerous situations
- has reasonable skills in managing the child's behavior

Familial, Social and Economic

Protective Factors

- family has successfully managed major stress in the past
- caregiver is engaged with support person or groups
- extended family recognizes limitations of parent and makes adequate arrangements for child's safety
- non-offending caregiver is able to take primary responsibility for protecting child
- the family has sufficient financial means to provide reasonable accommodations to care adequately for the child

Collecting Information for Completing the Investigative Risk Assessment

The more information gathered about each particular risk factor, the more accurate the assessment of the level of risk for that factor. Likewise, the same is true for the protective factors. The more information available on each protective factor, the more accurate the assessment of how that protective factor reduces the level of risk. It is important to gather as much information from as many credible sources as possible. Reliable information will lead to a more accurate assessment of the overall level of risk. Sources of information for completing the investigative risk assessment might include:

- parents and extended family;
- potential witnesses;
- the child;
- the child's medical provider;
- the caregiver/alleged perpetrator;
- a physician or nurse;
- observations and documentation from home visits;
- case history in CPS file;
- the jurisdiction where family previously lived;
- law enforcement for information about criminal behavior related to child maltreatment;
- other social service agencies that have had previous contact;
- victim's siblings;
- neighbors, especially in chronic neglect cases; and
- schools and childcare providers.

Here are some examples of questions that might be used in interviewing parents or others in collecting data regarding risk factors:

Child Characteristics

Vulnerability/Self protection

- Does the child attend childcare or school?
- Is the child involved in any activities outside of school?
- How does the child get to and from school?
- Who is home before and after school with the child?
- How do you know when the child is hurt or upset?
- Is the child easily comforted?
- How do you comfort the child?
- In addition to you, who else does the child see on a regular basis?

Special Needs/ Behavior problems

- What are any difficult child behaviors that have been identified by school or child care professionals?
- Describe any eating or sleeping habits of concern.
- What behavior does the child have that is difficult for you to manage?
- Has your child ever hurt another child?
- Describe any special needs that the child might have.

Caregiver Characteristics

Substance Abuse

- What is the current status of any drug or alcohol use?
- Describe your drug history, including frequency of use, type of drugs.
- Describe any treatment for drugs or alcohol, including dates, duration, completion?
- If in recovery, describe length of time in recovery and relapse history.
- Describe any criminal history you have related to drug and alcohol use?
- What affect has your current or past drug/alcohol use had on your ability to parent your child?
- Are there any other adults in your home whose drug use would affect the safety of the child? If so, explain.

Mental, Emotional, Intellectual or Physical Impairments

- Describe, if any, past or current history with a therapist, psychologist or counselor?
- If you have ever been hospitalized for your mental or emotional health, please describe?
- Describe, if any, your history of medication for a mental or emotional condition?
- Has your mental or emotional condition ever affected your ability to meet your child's needs? If, so describe.
- Describe any other disability that would impair your ability to adequately provide for your child.

Parenting Skills/Expectation of Child

- What is your child capable of doing at this age?
- Do you feel that your child is capable of doing what you would expect them to be doing at this age? If not, describe.
- What is the level of agreement between you and your partner about what your child is able to do at this age?
- What happens when your child is not able to do what you expect?
- How do you help your child achieve developmental expectations?

Empathy/Nurturance/Bonding

Observation of the parent and child may provide useful information. Look for:

- physical contact between the child and the parent
- eye to eye contact
- parent's tone of voice used when communicating with the child
- parent's attention to child's needs during interview

Questions to ask:

- Describe your relationship to the child.
- Describe how you spend time with your child each day.
- How do you attend to your child's needs?
- Whom does your child seek for comfort?

History of Violence by or Between Caregivers Toward Peers and/or Children

- Describe, if any, your history of sexual assault, domestic violence or any other acts of violence.
- Describe your relationship with your partner.
- Describe your access to the family's financial resources.
- How do you resolve conflict?
- If needed, do you have a safety plan in place for you and your children? If so, describe.

Protection of Child by Non-Abusive Caregiver

- What did the offending caregiver do to harm your child?
- How do you think this has affected your child?
- What is your relationship to the offending caregiver?
- What is your plan to protect the child in the future?

Recognition of Problem/Motivation to Change

- What were the reasons stated by CPS for intervention at this time in your life?
- What areas of parenting would you like to improve?
- What is needed for you to ensure your child's safety?
- From your perspective, explain the issue that brought your family to the attention of CPS.

History of CA/N as a Child

- Where did you grow up?
- Describe your family of origin?
- Describe the important adults that were part of your life as a child.
- How were you disciplined as child and how did that make you feel?
- Describe any behavior that you felt was neglectful or abusive as a child?
- Describe any involvement, if any, that CPS had in your life as a child?
- How do you feel your experiences while growing up have influenced your ability to care for your own child?

Level of Cooperation with Intervention

- What kind of help do you need to meet the needs of your children?
- Who do you think could provide the help you have indicated that you need?
- Describe any past or current services that you received to help with your children.
- Describe your commitment in working cooperatively to resolve the issues related to your child.
- Describe how you view your current relationship with CPS.

Familial, Social and Economic Factors

Stress on Family

- Have there been any major changes to your family within the last year?
- How have these changes affected you?
- How is your child dealing with the changes?
- Describe any daily stress that is currently difficult for you to handle?
- How do you manage daily stress?

Social Support for Family

- What is your relationship with your family like?
- What family members live nearby that are willing to help you when you need something?
- What friends live close by and are willing to help you when you need it?
- Who else can you turn to when you need help?
- What kind of support do you need from your family, friends or community?

Economic Resources of Family

- What is the status of your current employment?
- What financial resources do you have to support your family?
- Do you have a car or access to public transportation?
- Are you able to provide for the basic needs of your family?
- What outstanding needs are difficult for you to provide on a consistent basis for your family?

Intake Risk Assessment and Investigative Risk Assessment

The guidelines used for determining the overall level of risk using the investigative risk assessment are similar to the process used to determine the overall level of risk using the intake risk assessment.

The intake risk assessment is a preliminary assessment designed to quickly determine the response time and risk tag for CPS referrals, based on partial information from a limited number of collateral sources. The investigative risk assessment differs from the intake risk assessment in the following ways:

- it is a more comprehensive assessment;
- data is collected from multiple sources;
- more information is collected from family and extended family;
- information is available to more accurately determine risk factors and protective factors;
- overall level of future risk is determined and;
- it is used to determine case planning.

How to Determine the Overall Level of Risk

Some useful guidelines in assessing the overall level of risk using the investigative risk assessment include:

- assess chronicity and severity of risk factors particularly if they are combined with other risk or protective factors;
- special weight should be given to the history of child abuse and neglect;
- recent history of CA/N is the single best predictor of future CA/N;

- the number and interaction of identified high risk factors is usually more important than the presence or absence of any one factor;
- the overall level of risk assumes the likelihood of CA/N absent any successful intervention
- serious history of CA/N with multiple high risk factors generally demonstrates a high level of overall risk;
- a less serious history of CA/N combined with multiple protective factors usually indicates a low level of overall risk; and
- the needs and vulnerability of the child must be considered.

While not designed as mathematical equation, the following provides a formula for assessing the overall level of risk:

Baseline + Risk Factors - Protective Factors = Overall Risk Level

Baseline Level of Risk

The investigative risk assessment uses history of child abuse and neglect as the first risk factor. The history of child abuse and neglect is used to determine the baseline level of risk.

Risk Factors

The investigative risk assessment further identifies 15 risk factors that would increase the risk of future child abuse and neglect. The number of risk factors rated in the moderately high to high category need to be considered when determining the overall level of risk. The more risk factors rated in the high category, the more likely the overall level of risk is increased for the child. While the number of high risk factors is important to consider, it is also important to assess the nature and degree of each risk factor.

Protective Factors

The investigative risk assessment identifies protective factors that would reduce the risk of future child abuse and neglect to a child. In assessing protective factors it is important to consider:

- How significant are the protective factors?
- Is there a connection between the protective factors and the identified risk factors?
- How will the protective factors be applied to reduce risk to the child?
- Will the protective factors be in place as long as the identified risk factors exist?

The Overall Level of Risk is a Professional Judgement

Families in which multiple risk factors are present but in which evidence of CA/N is lacking are not uncommon. Some of these families may genuinely be at high risk for future CA/N related harm to a child but there may be protective factors that have been operating effectively to reduce the child's vulnerability to harm. The lack of evidence of past CA/N is not, in and of itself, enough to conclude that a child is at low risk of CA/N related harm.

Current knowledge indicates that the overall risk of CA/N is a product of the interaction of risk factors rather than the presence or absence of any one or two factors. The risk assessment model assumes that the risk of CA/N is a balance between risk factors that increase the probability of CA/N and protective factors that diminish the likelihood of CA/N.

The investigative risk assessment is intended to assist in collecting family information about risk factors and protective factors. It is a tool that can assist social workers in making judgements about future risk of child abuse and neglect. It is not intended to replace critical thinking.

The investigative risk assessment can not be used to simply add up the number of high risk factors and protective factors and get an accurate assessment of risk. Rather, an understanding of CA/N and sound social worker judgement is needed to determine an overall level of risk.

Investigative Risk Assessment

Example (Not based on an actual case)

CHILDREN'S ADMINISTRATION

Washington State Department of Social & Health Services

To be completed at the completion of the investigation and no later than the 90th day after the referral is received.

Assessment ID:

Case ID:

Worker ID

Referral ID(s)

Assessment Date: 05/07/01

Case Name: Brenda Jones

Worker Name:

Office Name:

I. Baseline Level of Risk: 3 - Moderate Risk

History of CA/N (Prior to the current allegations. Include victimization of any child and describe injuries or accidents related to CA/N, dangerous acts/neglectful conditions, extent of sexual abuse, and developmental/emotional harm.)

While babysitting a half year ago, the 2 year old in her care wandered into the street while she was talking on the phone. According to the parent, when Brenda located the child she proceeded to spank the child to bruising. The incident was reported to CPS as a 3rd party referral. Law enforcement was contacted. No legal action was taken.

Description of most recent CA/N (Include comments on severity, frequency and effects on child.)

Brenda Jones had been seeing a therapist for issues related to an extensive history of physical abuse and neglect as a child. That therapist grew concerned about Brenda's newborn daughter and called in a CPS referral that included the following information:

The mother is 16 years old and gave birth two months ago to her first child, a daughter named Molly. The mother reported to her therapist that she used cocaine and marijuana until she became pregnant and then, as reported by her obstetrician, did not test positive for drugs during her pregnancy. The baby was born healthy. Pre-natal checks, however, were erratic. A referral for a public health nurse was made by the hospital. The mother has not followed up on the referral. Brenda also left her two month old daughter home unsupervised. Brenda told the referent that she had "just run to the store to buy formula and it was only two blocks away." Brenda does not appear to understand the risk she placed her infant in by leaving her child home alone but has agreed she would never do it again. (A neighbor contacted the therapist and told her that Brenda was gone for at least 45 minutes and believes Brenda bought beer). The mother has been moving around, staying with various friends. She indicates that she just moved in with her sister. The mother is described by her therapist as angry and defiant with an explosive temper. This temper combined with her immaturity, her own extensive history of childhood abuse, her simplistic understanding of her child's needs and unwillingness to accept help, may potentially lead to an episode of abuse.

The father of the child is unknown. The mother reports that she became pregnant while living on the streets and that she does not know the identity of the father.

II. Child Characteristics:		Explanation
1. Vulnerability/Self protection skills *Jones, Molly M.*	Risk 5	*Infant is totally dependent on a safe reliable adult to meet her needs*
1. Special Needs/Behavior problems *Jones, Molly M.*	Risk 0	*At this time the infant is making normal gains and is developing on target. PHN will be monitoring developmental milestones and will report any concerns when noted.*

III. Caregiver Characteristics:		Explanation
1. Substance Abuse *Jones, Brenda K.*	Risk 4	*Mother has extensive drug use history. Mother reports she has abused marijuana and cocaine. She reports that she stopped using substances when she learned that she was pregnant. Her prenatal appointments were erratic. However, UA's were clean when she did show. Baby was born healthy. Mother is currently refusing to participate in D/A evaluation but did agree to participate in weekly UA's beginning next week. Mother refused to do an immediate UA leading this SW to question if the UA would have been positive.*
2. Mental/Emotional, Intellectual, or Physical Impairments *Jones, Brenda K.*	Risk 4	*Mother has been seeing therapist to address extensive childhood issues. Mother is described by her therapist as angry and as having an explosive temper. Appointments have been sporadic.*
3. Parenting Skills/Expectation of child *Jones, Brenda K.*	Risk 4	*This is a very young mother who has limited understanding of her child's needs and has limited exposure to healthy parenting due to her own childhood. Mother at times is reluctant to accept outside advice. Mother's short temper is very concerning. Mother's sister is a positive parenting role model.*
4. Empathy, Nurturing, and Bonding *Jones, Brenda K.*	Risk 4	*Mother does not appear to be bonded to her infant and is the primary caregiver for her daughter.*
5. History of violence by or between caregivers toward peers and/or children *Jones, Brenda K.*	Risk 2	*Mother physically abused a two year old she was baby-sitting approx. six months ago. The toddler had run out into the street she spanked the child which resulted in a hand print bruise on his bottom. This was a third party referral, no criminal charges were filed. This appears to be an isolated incident.*
6. Protection of child by non-abusive caregiver *Jones, Brenda K.*	Risk 9	*Brenda has recently moved in with her sister, it is unknown at this time how supportive or protective she will be.*
7. Recognition of problem/motivation to change *Jones, Brenda K.*	Risk 4	*Mother at this time only has a superficial understanding of the problem. While mother is currently willing to engage in services her follow through and ability to change is unknown at this time.*
8. History of CA/N as a child *Jones, Brenda K.*	Risk 5	*Mother was neglected and physically abused as a child and lived in various foster homes throughout her life. Mother was on the streets living with various friends during the last year.*
9. Level of cooperation with intervention *Jones, Brenda K.*	Risk 3	*Mother is currently accepting intervention but states she is only doing so to get CPS off her back.*

IV. Substance Abuse

Jones, Brenda K.
(yes) A determination has been made of whether it is probable that the use of alcohol or controlled substance is a contributing factor to the alleged abuse or neglect.

(yes) A referral has been made to a certified chemical dependency specialist or physician for a chemical dependency evaluation. The basis for the referral is documented by the indicators of substance abuse.

* Information is obtained from a credible source that the subject of the referral is abusing alcohol or other drugs or is involved in illegal activity involving illicit substances.

Mom's (Brenda's) therapist

Substance abuse by the subject was disclosed by the subject or the child during the interview process.
Disclosed by mom, Brenda

V. Familial, Social, and Economic Factors:

1. Stress on Family	Risk 5
2. Social support for family	Risk 4
3. Economic resources of family	Risk 3
4. Domestic violence Mom is not willing to discuss the issue	Risk 9

VI. Protective Factors

The mother is engaging in services.

* *She has recently accepted the help of a public health nurse (PHN) who comes to the home once a week. The PHN reports that the mother is making all appointments and is responding appropriately to her child's cues and needs and that the mother appears to love her baby. Nevertheless, the mother can be resistive to information and can grow impatient with the infant.*
* *The mother continues to attend therapy on a weekly basis and although their relationship is tense because of the therapist's report to CPS, the mother has said she thinks therapy is helping her.*
* *She has enrolled in a GED program and has begun to meet with a school counselor.*
* *The mother recently agreed to participate in random urinalysis testing which will begin next week.*

The mother is tending to her child's needs.

* *The mother has made all her well-child checks. The baby is making normal height/weight gains and is developmentally on target. No other issues have been identified at this time and the pediatrician says that she is a healthy baby.*

The mother is living with a supportive relative.

* *Brenda continues to live with her older sister Tammy. Tammy has been a consistent support to the mother and expresses a strong commitment to assisting her sister in the raising of her niece. Tammy has stable full-time employment and moved to a two-bedroom apartment to accommodate her sister and niece. She is very attached to and protective of her sister and niece. Tammy is the person that the mother trusts most and is most responsive to for assistance/guidance.*

The mother is seeking out other positive supports.

* *The mother has recently reconnected with one of her former foster parents, Joanne. The mother has begun to visit and brings the baby along. Joanne has agreed to care for the baby to give the mother some free time for her therapy, studies and other appointments.*

VII. Current Overall level of risk: 4 - Moderately High Risk

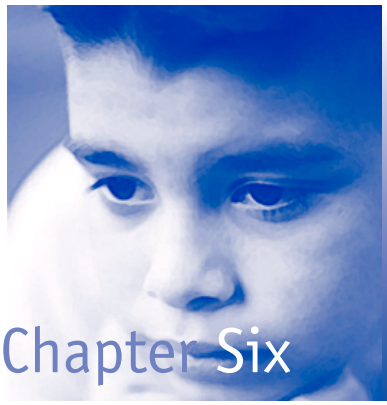
Basis for Overall Level of Risk

While it is very early on (and therefore, progress should be viewed with caution) the mother has nevertheless begun to take some positive steps in her parenting and in stabilizing her life. She is close with her sister and accepting of her help and support. She has reconnected with a foster parent and has begun to reestablish a relationship with her. She has enrolled in a GED program and continues to work with her therapist on her childhood abuse issues, her anger and impulsiveness. She is working with a PHN and has begun to develop a relationship with her. The baby is doing well and developing normally.

In addition to a specific incident involving a lack of appropriate supervision and over-discipline of another child in the mother's care, there are several other areas of high risk. Those areas include her age and immaturity, her untreated substance abuse, her childhood history of abuse and neglect, and the baby's level of vulnerability and need for protection. The mother struggles with unrealistic ideas of parenting and expectations of her own abilities to stay drug-free, meet her obligations and maintain a stable life while managing her emotional and psychological needs. She grows impatient with the baby, indicating a lack of understanding of the baby's developmental abilities. She is resistive to additional services that could help in this area, so far refusing to attend a parenting class for teen mothers and their babies. She has also refused to participate in a substance abuse treatment evaluation. She has recently agreed to participate in random urinalysis testing which will begin next week.

During this past month her volatility has lessened and she has involved herself in supportive services. She has strong support from her sister and she is accepting of her help. The sister is providing some financial support and the mother is receiving TANF and WIC support. The mother uses some of her TANF to help with rent and food. It is early in the case and the mother's progress has just begun.

Considering her concerning history and the risk factors mentioned, it is too early to be assured that the mother will continue to do well particularly as her child develops and issues of parenting begin to change. It is of great concern that the mother refuses to participate in a substance abuse evaluation considering her history of substance abuse and that the issues she is dealing with could trigger a relapse.



Chapter Six Reassessment of Risk

The reassessment of risk is the sixth step in risk decision making and answers the question, "Have risk levels changed?" The reassessment of risk contains the same 16 risk factors as the investigative risk assessment.

Refer to the Risk Assessment Decision-Making Chart on page five and the Risk Decision Flow Chart on page seven in Chapter One.

The purpose of reassessment of risk is to:

- identify specific changes in current risk factors in comparison to the identified previous risk factors in the investigative risk assessment
- accurately assess current risk of child maltreatment
- draw appropriate conclusions of current overall risk based on data, observations and interviews
- compare current protective factors to protective factors in the investigative risk assessment
- assist social workers in evaluating the effectiveness of the intervention
- apply the results of the reassessment to case planning

Timelines and Documentation

The reassessment of risk is completed:

- on CA/N related cases
- at case transfer, every six months and case closure on open cases after completion of an investigative risk assessment if no ISSP is required

When completing a reassessment of risk, the social worker must examine any prior risk assessments done on the case. The current assessment must identify and include significant risk factors identified on prior assessments. Significant changes in any identified risk factor should be carefully documented.

When is a Reassessment of Risk Not Required?

If an investigative risk assessment or reassessment of risk has been completed within the previous 30 days on an open case with no ISSP and no significant change has occurred, a new reassessment of risk is not required at the point of case transfer or case closure.

How to Assess the Overall Level of Risk

The overall level of risk is taken directly from the most recent previous assessment of risk. The reassessment of risk identifies both risk factors and protective factors. The method for assessing the overall level of risk is based on the same principles that are outlined in Chapter Five on Investigative Risk Assessment.

Reassessment of Risk

CHILDREN'S ADMINISTRATION

Washington State Department of Social & Health Services

Example (Not based on an actual case)

Assessment Status: Complete

Assessment ID:	Assessment Date: 08/08/01
Case ID:	Case Name: Brenda Jones
Worker Name:	Worker ID
Office Name:	Referral ID(s)

Previous Risk Level: 4 Moderately High

I. Overall Level of Risk From Most Recent Previous Assessment of Risk:

From the 05/07/01 Investigative Risk Assessment completed 3 months ago:

While it is very early on (and therefore, progress should be viewed with caution) the mother has nevertheless begun to take some positive steps in her parenting and in stabilizing her life. She is close with her sister and accepting of her help and support. She has reconnected with a foster parent and has begun to reestablish a relationship with her. She has enrolled in a GED program and continues to work with her therapist on her childhood abuse issues, her anger and impulsiveness. She is working with a PHN and has begun to develop a relationship with her. The baby is doing well and developing normally.

In addition to a specific incident involving a lack of appropriate supervision and over-discipline of another child in the mother's care, there are several other areas of high risk. Those areas include her age and immaturity, her untreated substance abuse, her childhood history of abuse and neglect, and the baby's level of vulnerability and need for protection. The mother struggles with unrealistic ideas of parenting and expectations of her own abilities to stay drug-free, meet her obligations and maintain a stable life while managing her emotional and psychological needs. She grows impatient with the baby, indicating a lack of understanding of the baby's developmental abilities. She is resistive to additional services that could help in this area, so far refusing to attend a parenting class for teen mothers and their babies. She has also refused to participate in a substance abuse treatment evaluation. She has recently agreed to participate in random urinalysis testing which will begin next week.

During this past month her volatility has lessened and she has involved herself in supportive services. She has strong support from her sister and she is accepting of her help. The sister is providing some financial support and the mother is receiving TANF and WIC support. The mother uses some of her TANF to help with rent and food. It is early in the case and the mother's progress has just begun.

Considering her history and the risk factors mentioned, it is too early to be assured that the mother will continue to do well particularly as her child develops and issues of parenting begin to change. It is of great concern that the mother refuses to participate in a substance abuse evaluation considering her history of substance abuse and that the issues she is dealing with could trigger a relapse.

II. Child Characteristics:

1. Vulnerability/Self protection skills *Jones, Molly M.*	Risk 5	Explanation
2. Special Needs/Behavior problems *Jones, Molly M.*	Risk 0	

III. Caregiver Characteristics:

1. Vulnerability/Self protection skills *Jones, Brenda K.*	Risk 3	Mother has participated in 80% of random urinalysis testing and all UA's have been clean. Mother has not participated in an evaluation or any treatment however. Risk of relapse remains high.
2. Mental/Emotional, Intellectual, or Physical Impairments *Jones, Brenda K.*	Risk 2	Mother has continued in therapy, but participation remains sporadic. Mother's living situation has stabilized and she has sought out individuals willing to provide help and support.
3. Parenting Skills/Expectation of child *Jones, Brenda K.*	Risk 3	Mother has gained a better understanding of her child's needs and how to meet them.
4. Empathy, Nurturing, and Bonding *Jones, Brenda K.*	Risk 2	Mother is providing primary care to her daughter and the two appear bonded.
5. History of violence by or between caregivers toward peers and/or children *Jones, Brenda K.*	Risk 2	Explanation
6. Protection of child by non-abusive caregiver *Jones, Brenda K.*	Risk 0	Mother's sister has provided consistent protection of her niece.
7. Recognition of problem/motivation to change *Jones, Brenda K.*	Risk 2	Mother has made limited progress in several areas.
8. History of CA/N as a child *Jones, Brenda K.*	Risk 5	Explanation
9. Level of cooperation with intervention *Jones, Brenda K.*	Risk 3	Explanation

IV. Familial, Social, and Economic Factors:

1. Stress on family	Risk 5	Explanation
2. Social support for family	Risk 3	Mother and daughter are residing with mother's sister who is very supportive. In addition, mother has sought the support of her former foster parent.
3. Economic resources of family	Risk 3	Explanation
4. Domestic violence	Risk 9	Mother has not disclosed any current domestic violence.

V. Protective Factors

Identify and discuss protective factors and family strengths available to assist this child/family.

Brenda has made significant strides towards stabilizing her life since completion of the IRA. She continues to reside with her sister and this placement has been very positive for both Brenda and Molly. In addition, Brenda has sought out help from her sister and has been receptive to both her sister's advice and assistance.

Brenda has also reconnected with her former foster parent who is providing emotional support and an attentive ear along with daycare while Brenda attends her therapy appointments.

Reports from the Public Health Nurse indicate Molly is healthy and developing normally. In addition, Brenda has responded positively to the PHN's advice.

VI. Current Overall level of risk

Risk	Basis
3 Moderate Risk	*For the past three months, Brenda and her daughter, Molly, have resided with Brenda's sister, Tammy. During this period Brenda has made limited progress in both her parenting and in stabilizing her life. Nevertheless, there are a number of high risk factors where either no progress has been made or there hasn't been adequate time to make the progress necessary to ameliorate the problem. In particular, Brenda has not participated in a drug/alcohol evaluation or treatment. This issue relates to a high risk for relapse, as well as her recognition of the problem, her motivation to change and her level of cooperation with the intervention. In addition, Brenda's history of childhood abuse, her age and immaturity continue to be at issue and is compounded by her daughter's level of vulnerability and need for protection. In sum, the risk on this case is moderate. Nevertheless, there are areas where Brenda is making clear progress:* * *Brenda appears quite bonded to her daughter. According to Tammy, she is providing primary care for Molly and for the most part is doing a good job of meeting her daughter's needs. She becomes frustrated at times with her daughter's crying, but has been quick to ask for her sister's assistance to both calm her daughter and to get relief from a stressful situation. Overall, she has made progress in her parenting skills - having now a much*

better understanding of Molly's needs and how to meet them. Nevertheless, Brenda has demonstrated an explosive temper in the past. As such, there is concern that her frustration may escalate (and Molly harmed in the process) if there is no one to turn to in times of stress. As a result, close monitoring and on-going support from her sister and others remains vitally important.

* *Brenda reconnected with her former foster parent, Joanne. Brenda calls Joanne regularly just to talk and Joanne babysat Molly on several occasions so that Brenda could attend her therapy sessions. So far, the relationship had been very positive with Brenda seeing Joanne as a very supportive person in her life.*
* *Brenda has continued attending therapy although according to the therapist, progress had been slow with some residual trust issues (due to the therapist's report to CPS) continuing to crop up. In addition, her attendance has been inconsistent with Brenda attending only 3 of the past 5 sessions. As a result, there had been some discussion about changing therapists.*
* *Brenda made 75% of the weekly appointments with the PHN during this three-month period. (Brenda no-showed twice and called to cancel once.) Nevertheless, reports indicate that Molly is healthy and developing normally. Brenda reportedly responds appropriately to Molly's cues, however, Brenda has been noted to become frustrated when she is unable to quickly console Molly and stop her crying. At the same time, Brenda has responded positively to the PHN's advice in dealing with this situation. The PHN, nevertheless, feels strongly that Brenda needs ongoing support and coaching if she is going to be able to adequately care for her daughter in the long run.*
* *Brenda decided to delay pursuing her GED for the time being - feeling that life was too busy right now and that she would have more time later.*
* *Brenda has participated fairly regularly in random urinalysis testing - making it in for testing 80% of the time. To date all UAs have been clean. She has not, however, participated in a drug/alcohol evaluation although agreement to participate in this service was recently obtained. In sum, the risk of relapse has not been reduced due to the lack of an evaluation/ treatment and as such, the risk remains high.*

Brenda has made some clear strides in the past 3 months. Her living situation has stabilized. She is accepting guidance and support from her sister. She has reconnected with her former foster parent who is also providing help and support. And most importantly, her daughter is healthy and developing on target.

Nevertheless, this case is moderate risk. High risk factors continue to include her age and immaturity, her untreated substance abuse, her childhood history of abuse and neglect (which due to her inconsistent participation in counseling is not being adequately addressed), and the baby's level of vulnerability and need for protection.

As a result, it is recommended that this case remain open and that the following additional services be offered:

* *Drug/alcohol evaluation*
* *Participation in a parenting class for teen mothers and their babies*
* *Pursue change in individual therapist*

Chapter Seven

Reunification Assessment

The reunification assessment is the seventh step in risk decision making and answers the question, "Is it safe for the child to return home?"

Refer to the Risk Assessment Decision-Making Chart on page five and the Risk Decision Flow Chart on page seven in Chapter One.

The Purpose of the Reunification Assessment

The reunification assessment is used to identify conditions that have significantly changed so that reunification may occur. The reunification assessment is also used to:

- assess risk of harm due to CA/N if child is reunified;
- evaluate the effectiveness of service plans in reducing risk;
- assess caregiver's capability to parent the child;
- assess the impact of reunification on child and family;
- structure the decision making process for reunification; and
- provide rationale for reunification decision.

Timelines and Documentation

For *all* children in care longer than 60 days due to child abuse or neglect, a Reunification Assessment will be completed before a reunification decision is made. This will be completed prior to all court review hearings in which reunifiction has been determined as the permanent plan. The decision to reunify shall be documented in the Reunification Assessment and will state why reunification is the case plan.

A child reunified with a parent following placement in out-of-home care less than 60 days due to abuse or neglect, will either have a safety assessment and safety plan or a transition and safety plan completed prior to the reunification of the child. The tool used is at the discretion of the supervisor and worker. Supervisory review of the plan will occur as part of the decision-making process to reunify the child with the family. Completion of a reunification assessment is not required.

Reunification assessments should only be completed for the purpose of assessing parent(s) that were involved in the initial removal. If the constellation around such a parent has changed (for example, mother is now living with a new paramour) then the new paramour should be included in the reunification assessment. In cases where consideration is being given to placing a child with

caregivers not part of the initial removal, the Reunification Assessment should not be used. In such cases a home study is the appropriate tool for evaluating the potential placement.

Children being placed with caregivers who were not part of the initial out of home placement will not need to have a reunification assessment completed. In such cases a home study is the appropriate tool for evaluating the potential placement.

Completing the Reunification Assessment

The reunification assessment contains the same 16 risk factors as the investigative risk assessment and the reassessment of risk. When completing a reunification assessment, the social worker must examine prior risk assessments completed on the case. The current reunification assessment must consider significant factors identified on prior assessments. Significant changes in risk factors and protective factors should be documented.

The reunification assessment requires documentation in the following areas:

- Parent, guardian, or legal custodian's capability to parent this particular child to include:
  1. the parent's emotional and psychological preparedness for the child's return home
  2. the parent's empathy for the child's feelings of grief and loss
  3. parental ambilvalence regarding reunification
- Protective factors, family strengths and improvements in family functioning
  1. indentification and sufficiency of the natural support system available to the family
- Potential impacts of reunification on child's well being including:
  1. the child's cultural needs, including language, food and family traditions
  2. the developmental stage of the child when he/she entered care and when he/she returns home, including the length of stay in placement
  3. a review of the reason the child came into care, initial risks to the child and the safety threats at the beginning of the placement
  4. contacts for visitation with parent to include medical appointments, therapy sessions, school activities and other appropriate activities to maintain parental responsibilities, family connections, and other community connections
- Potential impact of reunification on family's well being including identification and sufficiency of the natural support system available to the family;
- The attachment between the child and caregivers/resource family
- Issues of grief and loss for the child and caregiver/resource family at the time of separation
- Current overall level of risk
- Recommendation for reunification

The following are some examples of questions to be considered when completing the reunification assessment:

Caregiver capability to parent this particular child?

Consider any changes in the parent's current ability to adequately provide for the child's needs. Consider the parent's abilities as they relate to the particular needs of the child. Look for examples of the parent's current behavior that demonstrates the parent's ability to care for the child.

- Is the child comfortable in the parent's presence? Does the child seek comfort from parent?
- Did the parent visit regularly prior to reunification?
- What was the quality of the parent/child relationship demonstrated during visits?
- Has the parent indicated a desire to parent, or made any comments expressing ambivalence?
- Does the parent understand this child's needs?
- Has the parent demonstrated a capacity to consistently meet the child's needs?
- To what degree have the factors that impaired parental capacity at the time of removal been remedied?

Protective factors, family strengths and improvements in family functioning.

Assess how the protective factors and family strengths will address each identified risk factor. Consider the ability of the parent to be consistent in the new behavior given the additional stress associated with the child returning home.

- What support, including extended family, is present to assist the parent in caring for the child?
- Are parental/family strengths as identified in the original investigative risk assessment and reassessment still valid protective factors?
- What new protective factors or family strengths are present?

Potential Impact of Reunification on Child's Well Being

Consider how the child's emotional well-being and behavior will be affected by the return home. Assess the child's sense of security, level of anxiety and ability to adjust to changes if returned home. How will the continuity of services as identified in the ISSP be assured for the child if returned home? How will those changes affect the child? How will the child react to the changes in family functioning, family constellation and housing accommodations? Consider the length of time in out of home care and the attachment to foster parents and siblings.

- If child is verbal, what feelings does child express about reunification?
- If child is non-verbal, what do child's observed behaviors indicate about the child's likely comfort level if reunified?
- How will the child's needs, as identified in Kidscreen, be met if reunification is accomplished?
- Are there changes in family circumstances since the child's removal that will impact on child's well being?
- What safety issues need to be considered for this child?

Potential Impact of Reunification on Family's Well Being

Consider how reunification of the child will affect the family's functioning, relationship to each other and current family stability. How will the family's resources, both emotionally and financially be impacted by the child's return home? Consider how changes in sibling relationships and partner relationships will be impacted if the child is returned home.

- What needs have changed for the child that will impact the family? What are the feelings of family members about having the child returned?

- How would return of this child impact the care given to any other children in the home?
- What adjustments will the family have to make to accommodate this child's return?
- What will be the impact of this child's return on parenting resources?

Current Overall Level of Risk

The current overall level of risk is based on the investigative risk assessment, reassessments and the current reunification assessment. The method for assessing the overall level of risk is based on the same principles that are outlined in Chapter Five on the Investigative Risk Assessment.

Recommendation for Reunification

The justification for or against reunification needs to be clearly documented based on the factual information gathered in the reunification assessment. The recommendation for reunification must be based on conditions that currently exist in the family and not based on a potential service plan that could be put in place. In other words, "Are conditions safe for the child to return home right now."

If the recommendation is for return home, a transition and safety plan is required for children age 11 years and younger. The recommendation to return home should be done in conjunction with a service plan outlining the parent's participation in services.

Reunification Assessment

CHILDREN'S ADMINISTRATION

Washington State Department of Social & Health Services

Example (Not based on an actual case)

Assessment Status: Complete

Assessment ID: 0000
Child ID: 101010
Worker Name:
Office Name:

Assessment Date: 06/02/02
Child Name: Maria Sanchez
Worker ID:
Office ID:

Type of Assessment: Reunification

Current Assessment of Risk to Child if Child is Returned to Parental Home:

☐ 0 (NO) ☐ 1 (LOW) ☐ 2 (MODERATELY LOW) ☒ 3 (MODERATE)

☐ 4 (MODERATELY HIGH) ☐ 5 (HIGH)

I. Child Characteristics:

1. Vulnerability/Self protection skills *Sanchez, Maria M.*	Risk 2
2. Special Needs/Behavior problems *Sanchez, Maria M.*	Risk 4

0 - No Risk, 1 - Low Risk, 2 - Moderately Low Risk, 3 - Moderate Risk, 4 - Moderate High Risk, 5 - High Risk, 9 - Insufficient Information

II. Caregiver Characteristics:

1. Substance Abuse *Sanchez, Luis H.*	Risk 4
2. Mental/Emotional, Intellectual, or Physical Impairments *Sanchez, Luis H.*	Risk 3
3. Parenting Skills/Expectation of child *Sanchez, Luis H.*	Risk 4
4. Empathy/Nurturing, and Bonding *Sanchez, Luis H.*	Risk 2
5. History of violence by or between caregivers toward peers and/or children *Sanchez, Luis H.*	Risk 0
6. Protection of child by non-abusive caregivers *Sanchez, Luis H.*	Risk 0
7. Recognition of problem/motivation to change *Sanchez, Luis H.*	Risk 2
8. History of CA/N as a child *Sanchez, Luis H.*	Risk 0
9. Level of cooperation with intervention *Sanchez, Luis H.*	Risk 3

0 - No Risk, 1 - Low Risk, 2 - Moderately Low Risk, 3 - Moderate Risk, 4 - Moderate High Risk, 5 - High Risk, 9 - Insufficient Information

III. Familial, Social, and Economic Factors

1. Stress on Family	Risk 4
2. Social support for family	Risk 2
3. Economic resources of family	Risk 3
4. Domestic violence	Risk 0

IV. Indications of caregiver capability to parent this particular child:

Maria was removed from her father's care 12 months ago due to chronic neglect stemming from alcohol abuse. Luis admits but minimizes his alcohol use, indicating much of the time that there is "no problem" or that it is "under control". Luis entered outpatient alcohol treatment on one occasion but dropped out after only a couple of months. Nevertheless, there have been no reports of drinking during the past four months. In addition, Luis has participated regularly in random urinanalysis and all testing has been negative.

Luis regularly visits with Maria and travels an hour by bus in order to see her. Both clearly look forward to their visits and enjoy the time they spend together. Observers note that Maria is animated in her father's presence but comes across as quite parentified as well, taking on a clear caregiver role. Luis states that his daughter is his "best friend" and that she understands him better than anyone else. Both indicate a strong desire to be reunited. Luis, in particular, expresses frustration and anger with "the system". He feels he has been treated unjustly by the department and can't understand why his daughter hasn't been returned to him long ago. Both tend to feel the problems Maria has been experiencing will go away once she is back in his care.

Since Maria has been placed into foster care, Luis has been afforded limited opportunity to demonstrate an improved capacity to parent. Nevertheless, there is concern that Luis minimizes the problems Maria is experiencing and may not have the parenting skills necessary to meet his daughter's needs. As a result, he may be ill prepared to care for his daughter once she is back in his care if he doesn't first have an opportunity to gain additional parenting skills and more realistic expectations for his daughter.

V. Protective factors, family strengths, and improvements in family functioning:

Luis has made some recent strides in stabilizing his life. He recently obtained employment and has made concrete steps towards obtaining stable housing (having put a down payment down on an apartment). In addition, all indications suggest that Luis is abstaining from alcohol use.

Luis has consistently indicated a strong desire to have his daughter returned to his care. In addition, Maria consistently expresses a strong desire to be with her father. While Maria appears parentified, the two do get along very well and have a positive rapport. There have never been any reports of physical or sexual abuse and Luis indicates that he does not believe in physical discipline.

Recently, Luis started participating in Maria's counseling. He indicates that this has helped him know his daughter better. Maria too, indicates counseling has helped her begin to talk to her father about the "hard stuff".

Both maternal and paternal family members live in the area and have made reports to CPS regarding Luis' behavior in the past. Both sides of the family continue to be involved and have indicated willingness to provide respite and anything else that could be of help if Maria were placed back with her father. Luis' relationship with Maria's maternal grandparents is somewhat strained. However, his relationship with his siblings is very positive and he hasn't hesitated to ask them for help in the past. Luis is particularly close to his aunt Enid and has stayed with her for brief periods.

VI. Potential impact of reunification on child's well-being

Maria has consistently expressed a strong desire to be reunited with her father. Maria was an only child when she was removed from her father's care and she would once again be an only child if she were returned. Maria is, however, now older and therefore, more able to protect herself and seek out help as needed. In addition, Luis has recently started accompanying Maria to her counseling appointments, which would provide an ideal venue to address problems as they cropped up. Nonetheless, Maria has significant behavioral issues that include lying, stealing, poor hygiene and difficulty getting along with others. In addition, Maria has long had difficulty in school getting along with peers, following school rules and in her academics. While Maria is currently attending special education classes and has made some clear strides, the rest of the issues remain problematic.

Luis has had no experience parenting a 10-year old and has never maintained his sobriety when parenting - let alone with a child with Maria's issues. Prior to reunification, it will be important to ensure that Luis has a clear understanding of the potential problems he will be confronted with and have demonstrated the necessary skills to address those issues.

VII. Potential impact of reunification on Family's well-being:

As mentioned, Luis strongly desires his daughter to be returned to his care. In order to accommodate Maria, Luis will need to obtain stable housing (which he is in the process of doing). If Luis continues with his current employment he will be able to financially support his daughter. Nevertheless, given Maria's behaviors while in foster care it is anticipated that parenting will be very challenging and have a strong potential to undermine his sobriety. Luis, however, has strong support from his siblings who have indicated willingness to provide respite, etc.

VIII. Current Overall Level of Risk: *3 - Moderate Risk*

Basis of overall risk:

Luis has not successfully completed a drug/alcohol program and continues to minimize the severity of his problem. While he is apparently maintaining his sobriety at this time he remains at high risk for relapse (particularly if compounded with the additional stress of parenting).

During the first 8 months Maria was been in care, Luis made little progress in stabilizing his life. He moved around a great deal, residing with various relatives on a short-term basis and in a number of homeless shelters. While his recent progress is significant, it is unknown whether he will be able to maintain this progress and keep the momentum alive over time.

In addition, there is concern that Luis has unrealistic expectations for both himself and for his daughter. Both seem to believe Maria's acting out behavior will evaporate with reunification. Luis needs to acquire a greater understanding of his daughter's problems and build skills that will allow him to successfully parent a pre-adolescent child.

IX. Recommendation Regarding Reunification:

Reunification is not recommended at this time. While Luis has made some clear strides, reunification at present would be premature. It is recommended that Maria remain in foster care at the present time and that another assessment be completed in 3-6 months. In the interim, visitation should be increased to include overnights in preparation for possible reunification in the future. In addition, Luis should continue attending Maria's counseling sessions as recommended and become more involved in Maria's school activities. It is recommended that Luis begin meeting with a Home Support Specialist to provide coaching around parenting. Lastly, Luis will need to obtain an updated drug/alcohol assessment to determine if further alcohol treatment is still needed.

Maria has been in out of home care for 12 months. She needs permanence in her life. As such, alternative permanent planning will also be pursued at this time to ensure that Maria is in a permanent situation within the next 6 months.

Chapter Eight

Transition and Safety Planning

The transition and safety plan is the eighth step in risk decision making and answers the question, "How will the safety of the child be ensured?"

The results of the reunification assessment are used in developing the transition and safety plan. In particular, the safety plan should specifically address any high risk factors that were identified as concerns on the reunification assessment. The transition arrangements should specifically focus on the needs of the family and child as identified in the service plan in the ISSP.

The transition and safety plan is to be developed in collaboration with the parents and the individuals that will be providing support to the family. Family meetings that provide for shared decision-making, such as family group conferences or family support meetings, can provide an opportunity to develop a mutually agreed upon transition and safety plan.

The Purpose of the Transition and Safety Plan

The purpose of the transition and safety plan is to:

- identify current safety needs for the child
- identify current protective factors for the child
- minimize trauma to child
- address child's needs
- consider safety issues
- support the parent towards a successful reunification
- support the overall success of the reunification

When is a Transition and Safety Plan Required?

A transition and safety plan will be completed when all children who are in care for 60 days or longer are returned home.

Timelines and Documentation

Unless the court orders a child be returned to a parent immediately, the transition and safety plan will be completed prior to transitioning a child to the parent. If the court orders the child returned immediately, then the transition and safety plan will be completed as soon as possible after reunification is accomplished. The social worker and supervisor should consult and mutually develop a reasonable timeframe for the transition and safety plan to be in place.

The transition and safety plan may be completed by hand on a printed copy of the Word form or it may be completed on the online form. In either case a hard copy of the transition and safety plan should be retained in the file. CAMIS documentation should consist of an SER entry reading: "Transition and safety plan completed this date. Hard copy in file."

The Safety Plan

The purpose of the safety plan is to address the child's safety needs related to the risk factors identified in the reunification assessment. A safety plan needs to address the identified risk factors as identified in the most current assessment of risk. Each identified risk factor needs to be clearly and specifically addressed in the safety plan. There should be a clear link between each identified safety issue in the risk assessment and the identified safety measure put in place in the safety plan.

The safety plan is designed to anticipate and address problems before they occur and by doing so, ensure the safety and well being of the child. The safety plan identifies:

- the safety needs;
- the safety plan to address the needs;
- who will be responsible for addressing the safety needs; and
- timelines for addressing the safety needs.

Characteristics of Effective Safety Planning

Safety plans are most effective when they:

- focus on the child's safety needs;
- increase the child's visibility;
- include a number of parties who share the role of assuring child safety;
- are realistic and achievable;
- were developed in agreement with parents;
- are specific, detailed and contain timelines for completion; and
- clearly identify the roles and responsibilities of various adults in helping to keep the child safe.

The safety plan should be developed prior to return home and implemented as the transition home is completed. The safety plan remains in place and is monitored and modified by the social worker as safety needs change until case closure.

Transition Arrangements

The transition arrangements are not the service plan for the child and family. The detailed service plan is contained in the ISSP. The transition arrangements provide the details and mechanics for ensuring the continuity of the service plan following reunification. The transition arrangements should specifically focus on how the needs of the family will be met as identified in the service plan in the ISSP. Any needs identified in the Kidscreen evaluation results, staffing and action plan should also be included.

The transition arrangements are intended to ensure that the medical, educational and basic physical needs of the family are met upon the child's return home. There are eight sections under the transition arrangements. Those include:

Medical Care

Identify medical provider, how medical records will be transferred and if an EPSDT needs to be completed. Include eye care under this section.

Dental Care

Identify the dental provider and how records will be transferred to the new provider.

Emotional/Behavioral Needs

Identify mental health conditions, behavioral management plan, and other types of counseling and how those will be addressed. Include any other social service needs here.

School/Child Care

Document the name of the child's school and/or child care facility. If the child needs to be enrolled, discuss how records will be transferred and the plan for transitioning the child to the new school or child care facility.

Housing

Address the family's housing situation. Determine if the family needs to be referred for housing assistance.

Financial Assistance

Address any financial issues that are present. Families are eligible to add a child to the TANF grant 30 days prior to the reunification.

Visitation

Visitation should be incremental and regularly assessed to support reunification at a pace that meets the needs of the child and parent.

Other Arrangements

Identify any other arrangements that have not been discussed previously.

Parent Signatures

The signatures of the caregivers to whom the child is being returned shall be obtained and be present on the file copy of the form. The parents should also be furnished a copy of the signed document. If a parent does not sign the transition and safety plan, the social worker will document the date the agreement was obtained.

Follow Up for the Transition and Safety Plan

- monitor, review and revise the safety plan as needed
- communicate with those providing care and services to the family
- follow the guidelines and requirements as outlined in the in-home dependency policy, case management requirements

CHILDREN'S ADMINISTRATION

Washington State Department of Social & Health Services

Transition and Safety Plan

Example (Not based on an actual case)

A Transition and Safety Plan is to be completed following a positive reunification decision on the Reunification Assessment. It is required for all children, ages eleven and younger, returning to a parent following 60 days or longer in out-of-home care. For other children and youth, developing a transition and safety plan is encouraged.

Child's name: Brittany Nelson Date of plan: 05/12/02

Target date for return: 08/01/02 Date plan to be reviewed by planning team: 07/01/02

The Transition and Safety Plan sets forth the tasks to be completed before and after reunification occurs in order to ensure the safety and well being of the child. This requires that certain basic services are set up for the child in his/her new home, that visitation is designed to facilitate a smooth and careful transition, and that a plan is in place to monitor the child's safety. Additionally, this document is designed to build upon information outlined in the Kidscreen Evaluation Results – Staffing and Action Plan so that the plan developed while the child has been in care may continue once the child returns home. Services that are contained in the ISSP need not be repeated in this document.

Safety Plan for the Child:

What are the current safety needs (based on the reunification assessment matrix) as they return home? What protective factors will be put in place to monitor and support the child's safety in the home of his/her parent?

Safety need:	Safety plan:	By whom:	By when:
To ensure that Brittany is appropriately supervised all times.	Mom Nelson agrees to not leave Brittany unattended under any circumstances for any length of time.	Mom Nelson	Begin immediately
	Aunt Susan agrees to randomly check (by phone or in person) to see if Brittany is being properly supervised. Checks to occur once a week initially and to increase to twice a week with the June liberalization in visitation.	Aunt Susan	To begin immediately
	If Mom Nelson has problems providing supervision for Brittany due to a family emergency or other factor, she will call Aunt Susan or a neighbor to provide assistance. The SW will visit aunt Susan and the neighbors, run criminal history checks, review the supervision rules, and check each home for safety. Aunt Susan and neighbors Johnson and Sanders will each meet with the SW and cooperate with providing needed information	SW, Aunt Susan, Neighbors Johnson and Sanders	Background checks, etc. to begin immediately. Plan to be in place by 6/01/02.

Transition and Safety Plan *continued*

Safety need:	Safety plan:	By whom:	By when:
To ensure that Brittany is protected from mom's former boyfriend.	Mom Nelson will take out a Restraining Order against Robert Mills. Mom Nelson agrees to not communicate with Robert Mills in any way. If Robert Mills calls, Mom Nelson agrees to hang up immediately and call 911. If Robert appears at her home, Mom and Brittany agree to leave by the backdoor and go to either Neighbor Johnson or Sanders home and call the police immediately.	Mom Nelson, Brittany, Neighbor Johnson and Sanders	Begin immediately
	Aunt Susan will pick up Brittany after school on Thursdays (at 3:00). She and Brittany will spend a minimum of 1 hour together away from the home. Susan will talk to Brittany about the events during the week, any problems that have come up and will focus specifically on whether Brittany has been left alone or if she or her mother have had any contact with Robert Mills or any new boyfriends. Susan to immediately report any problems or issues to the SW.	Aunt Susan, Brittany and Social Worker	Begin immediately
To ensure that Brittany's safety is not jeopardized by any of mom's new boyfriends.	Mom Nelson agrees to not allow any contact between Brittany and any of her male friends without the Social Worker first conducting a criminal background check and CPS check. Mom agrees to abide by the SW's recommendations for contact (based on the criminal history check and CPS check).	Mom Nelson and Social Worker	

Transition Arrangements:

The child's needs and the service plan to meet those needs are contained in the ISSP. The Transition Arrangements are to describe how that plan will be carried out.

Medical Care:	*Who will be the new medical provider, does the child require an EPSDT be completed? How will medical records be transferred to the new provider? (Include information on optometrist if appropriate.)* Brittany is currently seeing Dr. Young. Mom Nelson has gone to her Doctor (Dr. Stephens) to set up services for Brittany there. She has signed a release of information and the medical records are being transferred. A well child appointment is scheduled for 05/04/02.
Dental Care:	*Who will be the new dental provider? How will dental records be transferred to the new provider?* Brittany is currently seeing Dr. Bart. Mom Nelson has gone to her dentist (Dr. Nash) to set up services for Brittany there. She has signed a release of information and the records are being transferred. An appointment for Brittany with Dr. Nash has been scheduled for 6/14/02.
Emotional/ Behavioral Needs:	*If there is a diagnosed mental health condition, how will it be addressed? If there is a behavioral management plan, how will that be carried out? How will counseling, if any, be continued? And finally, if there are any other social service needs, how will they be met?* Brittany will continue in individual counseling with Mary Jones at Highline Community Services. Mom Nelson will provide transportation for the weekly counseling sessions.
School/Day Care:	*Where will the child attend day care or school? Has the child been enrolled? Have records been requested for transfer?* Brittany will continue to attend Thomas Elementary. She will be in the 3rd grade next year. She will continue in the before and after school program at the YMCA. The social worker will write to the school and the YMCA to inform them of Brittany's transition home when this occurs. The school has agreed to provide transportation regardless of Christine's residence.
Housing:	*Is the parent's housing safe and sufficient to meet the family needs? Has the family been referred for housing assistance?* Housing is adequate in Mom Nelson's current home. Brittany will sleep in the bedroom and mom will sleep on the pullout couch in the living room.
Financial Assistance:	*Has the parent been referred to a financial worker to examine what assistance the family will be eligible for? Families can add a child to their grant 30 days prior to reunification.* Mom Nelson is scheduled for a meeting with the financial worker on 6/05/02 to review financial assistance when Brittany is returned home. If the transition plan is going smoothly, the social worker will provide Mom Nelson a letter indicating when it is anticipated Brittany will return home.

Transition and Safety Plan *continued*

Visitation:	*What is the visitation plan before the child is reunified with the parent? Does the visitation plan allow for visits increasing in length and unsupervised? How will the visitation plan be adjusted to meet the emotional needs of the child?* For the rest of May, Brittany will spend every Tuesday and Friday from 2:30-5:00 with her mother, unsupervised. In June, visits will be all day on Monday, Wednesday and Friday. In July, visits will be from Monday at 9:00am to Wednesday, at 5:00pm and from Friday at 9:00am to Saturday at 5:00pm. Meetings with Mom Nelson, the foster parent and the social worker to review the visitation plan are scheduled to occur on Tuesday – 5/31, Thursday – 7/15 and Tuesday – 7/25. Additional reviews may be scheduled at the request of any of the parties.
Other Arrangements:	*What other arrangements does the parent believe are needed in order to safely transition the child home?* Mom Nelson would like to join a support group for victims of domestic violence. The social worker will locate a support group and refer the mother within the next week. It is hoped that the mother may begin attending a support group before the end of the month. Grandma Betty will provide babysitting so that the mother may continue attending once reunification occurs and/or visitation is liberalized (creating a conflict).

Signatures (If participant does not sign, then DCFS social worker will document date agreement reached with participant for their participation in the plan):

_____	_____
Signature Date	Signature Date
_____	_____
Signature Date	Signature Date
_____	_____
Signature Date	Signature Date

Policy Statements Related to Kids Come First Initiative

DCFS Risk Assessment Tools

1. On all CPS referrals risk tagged 3, 4 or 5, in which the child is not placed in out-of-home care, the assigned social worker will complete a Safety Assessment immediately following the initial face-to-face contact with the child. The Safety Assessment may be initially documented directly in CAMIS or on NCR paper forms. In either case, the Safety Assessment must be documented in CAMIS according to the following timelines:
    - All referrals assessed as emergent and/or risk tagged 4 or 5 at intake, the Safety Assessment will be entered into CAMIS or completed on an NCR form within two working days of the initial face-to-face contact with the child. If the NCR form is used initially, the Safety Assessment form in CAMIS will be completed within ten working days of the initial face-to-face with the child.
    - On all referrals risk tagged 3/non-emergent at intake, the Safety Assessment will be entered into CAMIS or completed on an NCR form within ten working days of the initial face-to-face contact with the child. If the NCR form is used, the Safety Assessment form in CAMIS will be completed within ten working days of the completion of the NCR form.
    - If the Safety Assessment is completed on an NCR form, a hard copy of the form must be included in the hard copy case file.
2. When any question on the Safety Assessment has a response marked "indicated," the assigned social worker will also complete a Safety Plan. Safety Plans may also be completed on other cases as determined to be appropriate by the social worker and/or supervisor.
    - The Safety Plan may be completed by either direct entry into CAMIS or by completion of an NCR form.
    - If the Safety Plan is completed on an NCR form, a hard copy of the form must be included in the hard copy case file.
    - If the Safety Plan is completed on an NCR form, CAMIS documentation may consist of entry of the Safety Plan information into the CAMIS Safety Plan module or an SER entry reading: "Safety Plan completed on this date on NCR form."
    - If the Safety Plan is completed by direct entry into CAMIS, a copy should be printed and sent to the parents for their signature and to document they have the information in the plan. A hard copy should be placed in the Case Activity section of the file. Workers are strongly encouraged to obtain appropriate signatures on the hard copy of the form, even if it is directly entered into CAMIS. If parental signatures are not obtained, an SER should be entered noting the date a copy of the Safety Plan was sent to the parents.
3. If Safety Plans are required, completion of the Safety Plan will be documented in CAMIS according to the following timelines:
    - On all referrals assessed as emergent and/or risk tagged 4 or 5 at intake, the Safety Plan will

be documented in CAMIS within two working days of the initial face-to-face contact with the child.

- On all referrals risk tagged 3/non-emergent at intake, the Safety Plan will be documented in CAMIS within ten working days of the face-to-face contact with the child.

4. The decision as to whether an item on the Safety Assessment is marked "indicated" reflects the best judgement of the social worker based on the information available at the time of the assessment.

5. If a Safety Plan is not put into place within prescribed timelines and the child is not removed from parental custody, the social worker will document the reasons why a Safety Plan is not possible in the space provided on the Safety Assessment. The social worker shall confer with his/her supervisor regarding the case circumstances in a timely manner.

6. It is encouraged to obtain the signatures of the participants on the safety plan, especially that of the parents. This signature reflects their agreement to carry out their part of the plan. If the signatures of parents or other parties to the Safety Plan cannot be obtained, the assigned social worker may note in the signature block on the form the date on which verbal agreement as to the specific requirements of their involvement was reached.

7. The supervisor will review the Safety Assessment and Safety Plan according to the following guidelines:
   - On all referrals assessed as emergent and/or risk tagged 4 or 5 at intake, the Safety Plan will be reviewed within ten working days of its completion or sooner at the discretion of the worker and supervisor.
   - On all referrals risk tagged 3/non-emergent at intake, the Safety Plan will be reviewed at the regular monthly conference.
   - All Safety Assessments are to be reviewed at the regular monthly conference if not reviewed previously.
   - Supervisory review of Safety Plans completed in CAMIS will be documented in CAMIS, by opening the individual Safety Plans online and utilizing the button provided to indicate approval.
   - Supervisory review of Safety Plans completed on NCR forms will be documented by signing on the NCR form.

8. Under no circumstances will any case with an "indicated" response on the Safety Assessment be closed without supervisory review of both the Safety Assessment and Safety Plan.

9. If a child is reunified with a parent following placement in out-of-home care due to abuse or neglect, and the placement is less than 60 days in duration, either a Safety Assessment/Safety Plan OR a Transition and Safety Plan will be completed prior to the reunification of the child. The choice of which tool is used is at the discretion of the Supervisor and worker. Supervisory review of whichever tool is chosen for use will occur as part of the decision-making process to reunify the child with his/her family.

10. With approval of the Regional Administrator, under a regional plan, hand written NCR hard-copy Safety Assessments and Safety Plans may be input into CAMIS by designated clerical staff

according to the timelines set forth above. In all cases where Safety Assessments or Safety Plans have been completed on NCR forms, a copy of the original NCR documents will be retained in the paper file. The social worker will review the Safety Assessment and Safety Plan prior to clerical input to assure accuracy. Clerical staff inputting these documents will be authorized to check the "work complete" button on the CAMIS form. Administrative files should only be accessible to clerical input staff as authorized on a case-by-case basis by the owner of the administrative file.

11. The Summary Risk Assessment has been replaced with the Investigative Risk Assessment (IRA). It must be completed at the end of the investigation, but no later than 90 days after the date of the referral. In order to enable adequate supervisory review of findings, the data in Investigative Risk Assessments will not "lock down" until 30 days after the "assessment complete" button on the CAMIS form is checked.

12. When a case remains open for services after completion of an IRA, and no ISSP is required, a Reassessment of Risk will be completed at case closure, transfer, and every six months. If an IRA or Reassessment of Risk has been completed within the previous 30 days, and no significant change has occurred, a new Reassessment of Risk is not required.

13. For *all* children in care longer than 60 days due to child abuse or neglect, a Reunification Assessment will be completed before a reunification decision is made. This will be completed prior to all court review hearings in which reunification has been determined as the permanent plan. The decision to reunify shall be documented in the Reunification Assessment and will state why reunification is the case plan.
    - If the reunification is indicated or if reunification is ordered by the Court, a Transition and Safety Plan will be completed.
    - Unless the Court orders a child be returned to a parent immediately, the Transition and Safety Plan will be completed prior to transitioning a child to the parent. If the Court orders the child returned immediately, then the Transition and Safety Plan will be completed as soon as possible after reunification is accomplished.
    - The results of the Reunification Assessment shall be used in developing the Transition and Safety Plan.
    - All Transition Plans shall include a Safety Plan, ongoing services to be provided, and a plan for monitoring the child's well being.
    - Reunification assessments should only be completed for the purpose of assessing parent(s) that were involved in the initial removal. If the constellation around such a parent has changed (for example, mother is now living with a new paramour) then the new paramour should be included in the reunification assessment. In cases where consideration is being given to placing a child with caregivers not part of the initial removal, the Reunification Assessment should not be used. In such cases a home study is the appropriate tool for evaluating the potential placement.

Completion of the Transition and Safety Plan should be done in this fashion:

- The Transition and Safety Plan should be developed in collaboration with the caregivers to whom the child will be returning.
- The Transition and Safety Plan may be completed by hand on a printed copy of the Word form, or it may be completed by typing into the online form. In either case, a hard copy of the Transition and Safety Plan should be retained in the file.
- CAMIS documentation that the Transition and Safety Plan has been completed should consist of an SER entry reading: "Transition and Safety Plan completed this date. Hard copy in file."
- The signatures of the caregivers to whom the child is being returned shall be obtained and be present on the file copy of the form. The parents should also be furnished a copy of the signed document.

14. When completing an Investigative Risk Assessment, Reassessment of Risk or Reunification Assessment, the worker must review any prior risk assessments done on the case. Risk factors identified as significant in the current assessment should by justified in the narrative section of the current assessment.

Washington State
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CHILDREN'S ADMINISTRATION